Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Physician/ Jh. :39 2012 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution. **Examiner** 7. Age (in yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Min. Hours Director 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 X Yes 2 No more 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?.

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give Blac 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Unktion 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) abover Be permit. Page 1 and 2 should be filed 17. Father's Name (First, 18. Mother's Name (First, Middle, Maiden Surname) Middle, Last) lith and Mental H 27 is marked of r traumatic even ည Kobert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau altimore, Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Baltimore Donation 5 Other (Specify) e of Funeral Service License Signat North 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyn, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (midise) or condition ate Cause (Final Ph_sician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence bij. the attending physician and ched for use as the burial-transit Division of Vital Records, P.O. Box 68760 saler death. Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? been signed by the atte should be detached for Month Dav 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. co use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has page 2 1 Yes 2 🗌 No Hospital or Attending Physician: funeral director, 25. Was case referred to p 26. Place of Death (Check only one) Medical Certificate: To Be Other: 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other S ecity 1 Yes 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manna of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred within 24 hours at er death.

To the Funeral Director: After Natural 5 Pending Accident Investigation Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check State

DHMH 17 Rev 06-2011

Registrar

12-03974	
Linda Queen	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

inda Queen	1.	State of Maryland / Department of Certificate of	f Health and Mental Hy f Death	ygiene Reg. 1	No. 201	2 1750
Physician	/ 1	egistrar . Decedent's Name (First, Middle,Last)		Date of Death Month Da	ay Year	3. Time of Death 1855 hrs
Medical Examine		a, Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	May 25, 2012	2 4c. County of Death	
		5503 Wilvan Road	Baltimore		٨	//A
Funeral		. Social Security Number 6. Sex ,7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min	-	_ Co	inplace (State or Foreign untry)
Director	0	219-78-6990 1 M 2 F 49 Yrs		June 1	5, 1962	Maryland
ž		Jsual Residence of Decedent 0a. State	tion			10d. Inside City Limits
d how any	. 1	yarvland N/A	Baltimore	,		1 Yes 2 No
viaryland 28a-f show d at once.	Director	0e, Street and Number	Baltimore 10f. Zip Code 21207	10g.	Citizen of What Cou	ntry?
th the Maryland 23a or 28a-f sho notified at once.		5503 Wilvan Ave.			us	F Plack
th with	Funeral	1 Never Married 2 Married Armed Forces? If)	as Decedent of Hispanic Origin? (S) Yes, specify Cuban, Mexican, Puerto	pecity Yes or No- Rican, etc.)	White, etc.	ican Indian, Black,
ter dea		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2 No specify:		Specify: BC	ick
ours af	함	during m	nt's Usual Occupation (Give kind of nost of working life. DO NOT use ret		6b, Kind of Business/	Industry
36 in 72 h han "n lieal E		Elementary/Secondary (0-12) College (1-4 or 5+)	Disabled		N/	A
5-0036 liled within 7 Hygiene.	Completed	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Mai	den Surname)	
21215-00 uld be filed with Mental Hygien marked other c event, the M	æ	James Queen	JOAN J	Brown	City of Town State	a Zin Codo)
nore, MD 21215-0036 ges I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. It filtem 27 is marked other than "matural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at once	우	19a. Informant's Name/Relationship (Type, Print) 19b. Maillin 381	9 No CFOLK AV	C Balt	imore, M	aryland
ore, MD ss 1 and 2 sho of Health and If item 27 is her traumati	ŀ	20a. Method of Disposition 20b. Place of Dispo	sition (Name of cemetery,	Date 2	Oc. Location - City or	Town, State
Baltimore, Moemit. Pages I and 2 Department of Health Important: If item 2 Injury or other trauming or other trauming.		1 Burial 2 Cremation 3 Removal from State CYOWNSV	1 (11/12 1	Crownsvil	le Maryland
Baltimo permit. Page Department Important: injury or ot	ŀ	21. Signature of Funeral Service Licensee 22.	Name and Address of Facility	Ker Fyne	ral Home	PH 2429
		23a, Part I. Enter the disease, or complications that caused the death. Do not enter	512 Frederick;	Ave, Balgor respiratory arrest	shock, or heart	a ryland proximate Interval
Physician /Medical		failure. List only one cause on each line.				Between Onset and Death
Examiner	- [Immediate Cause (Final disease or condition resulting in death) a. Reflat Disease Due to (or as a consequence of):				
1	اي	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated				No.
and and - transit	Exa	events resulting in death) Last Due to (or as a consequence of): d.				
be execut sician and	dical	UNPENDED AMENDED				
68760, ertificate bo	w	IF FEMALE: 23c. If yes, outcome of pregnancy	etal death 3 Ectopic pregr	nancy	23d. Date of delive Month	ry Day Year
C 68	cian	past 12 months? 4 Pregnant at time of death 5 0	etal death 3Ectopic pregr Other (Specify)	iditoy	.,,=	
Box e death the atter	Physician/M	1 Yes 2 No 9 Unknown 9 Unknown	unded tipe source given in Port I	23e Did toba	acco use contribute to	o the cause of death?
rds, P.O. Box 68760 requires that the death erfificate been signed by the atte, ding phys hould be detached for ure as the b	P P	Part II. Other significant conditions contributing to death but not resulting in the	dindenying cause given in rait i.			obably 4 🗸 Unknown
ds, I				24a. Was an		autopsy findings available completion of cause of
Records. The law requirecate has been apage 2 should	Completed			perform 1 Yes 2	ed? death?	
tal Rection: The		25. Was case referred to medical	26.Place of Death (Chec			
Vita hysicia this ce	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie		3	esidence 6 🗸 Oth	er: Scene
Division of Vital Records, P.O. Hospital or Attending Physician: The law requires that 1.94 hours after death. Funeral Director: After this certificate has been signed by tely filled in by the funeral director, page 2 should be deace.		27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time o	f Injury 28c, Injury at Work?	28d. Describe no	w injury occurred	
IVISIOR Tor Attendather death Director: Jin by the	cati	2 Accident Investigation 28e Place of Injury - At home, farm, str				Rural Route Number, City
Division sopital or Attent hours after death meral Director: y filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify)		or Town, Sta	ate) 	
Di To the Hospital of within 24 hours a To the Funeral Completely filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ (Check only	curred at the time, date and place, at	nd due to the cause	(s) and manner as st	ated. the cause(s)
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigand manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (A	
	2	11 4 40 1/00 0 0 m 14	O.C.M.E.		May 31, 2012	
, h		30. Name and address of person who completed cause of death (Item 23a)				
8	2	Carol H. Allan, MD Assistant Medical Examiner 900 W	. Baltimore Street, Baltimor	e, MD 21223		
St Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	_	JUN U - LUIL LERON JO. 191		-		

DHMH 17 Rev 1/2001 DCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 12 per fh g929 7-24-12 vt
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 30. 2012 4:30 A M GEORGE SAMOS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD 9. Birthplace (State or Foreign Country) New York, New York If Under 24 Hrs 8. Date of Birth **Funeral** Davs Hours (Month, Day, Year, **Director** 064-12-8079 1 X M 2 D F 90 Yrs. Aug. 26, 1921 Usual Residence of Decede 28a-f shov 10a. State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 🂢 No Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1026 Deer Creek Church Road 21050 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force þ 1 Never Married 2 X Married XYes 2 Maryland 21215-0036 72 hours after If Yes, Give Year or Dates. should be filed within 72 hours aft and Mental Hygiene. 'Is marked other than "natural", 1 ☐ Yes 2 X No Specify: Specify: White 1981 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during in life, DO NOT use retired) Unk 16b. Kind of Business/Industry Unk (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+ 12 Be 17. Father's Name (First, Middle, Last) Unk 18. Mother's Name (First, Middle, Maiden Surname) Uhk မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh.
Department of Health ar
Important: If item 27 is
any injury or other trau Louis Sharkey (Grandson) 1026 Deer Creek Church Road, Forest Hill, Maryland 21050 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Evans Funeral Chapel Bel Air 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Forest Hill, Maryland 21. Signature p. Funeral Service Licensee Jeffrey R. 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services — Bel Air
3 Newport Drive, Forest Hill, Maryland 21050 Testerman (M01543) 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ C. deff with disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease Or Injury that initiated events Due to (or as a consequence of): burial-transit or Attending Physician; The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Month Day Year Pregnant at time of death 2 No 1 Yes 2 L 9 Unknown page 2 should be detached Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by demile 1 Yes 2 No 3 Probably 4 Unknown Din 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 No GETTIC STENESIND 2 🗌 No 1 Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 2 200 Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate; 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending ours after death.

neral Director; Af

filled in by the fu 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital c within 24 hours a To the Funeral D completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 50 2355 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W. MACPHAIL ROAD BEL AIR, MD. 21014 3. Registrar's Signature 31. Date filed (Month, Day, JUN 0 4 2012 Registrar

Examiner P.O. Box 68760, the Division of Vital Records,

Physician

/Medical

Examiner

Funeral

Director

28a-f shov items 23a or 28a-f shover instituted at

Funeral Director

þ

Completed

Be

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Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

29b. Signature and title of certifier

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

ulth and Mental Hygi 27 is marked other r traumatic event,

Health :

permit. Pages 1 and Department of Healt Important: If item 27 any Injury or other 1 once.

Physician /Medical

Baltimore, Maryland 21215-0036

or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: completely

in the past 12 mo 1 Yes 2 N 9 Unknown	onthe?	4 □ F	Live birth 2□ Feta Pregnant at time of d Jnknown		Ectopic Other (nancy fy)		Month Day Year
Part II. Other significa	nt conditions o	ontributing	to death but not res	ulting in the und	erlying	caus	se given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
Histor	79	DIA	BETE	5 Mz	51	4	ITUS	1 □ Yes	2 No 3 Probably 4 Unknown
								24a. Was an autopsy performed 1 Yes 2	
25. Was case referred	to medical						26. Place of De	ath (Check only one)	
examiner? 1 ☐ Yes 2 ☐ No		Hospital:	1 ☐ Inpatient 2 ☐	ER/Outpatient	3 🗆 1	OOA	Other: 4 Nursing	Home 5 ☐ Residence	6 ☐ Other (Specify)
27. Manner of Death 1 Natural 2 Accident	5 ☐ Pending investigation	(Date of Injury Month, Day, Year)	28b. Time of Injury	М	28c.	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. P	lace of Injury - At ho uilding, etc. (Specil	ome, farm, stree fy)	t, facto	ory, of	fice	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
		niner: On t							e(s) and manner as stated. and place, and due to the cause(s)

29c. License number

D12849

7680 OSLER BY. TOWSON MD 21204

29d. Date signed (Month, Day, Year)

6-1-12

State Registrar

backim 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D1.M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ethel May Slinkowski 2012 June 3:16 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours 080-32-8522 **Director** 72 Yrs. 1 □ M 2 🔀 F March 1, 1940 Elmhurst, New York Usual Residence of Decedent Director 10b. County "natural", or items 23a or 28a-f sho dical Examiner must be notified at 10c. City, Town or Location State New 10d. Inside City Limits 1 Yes 2 XNo Sullivan <u>Hampshire</u> Charlestown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Funeral 592 Sam Putnam Road 03603 of America 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white Completed 3 X Widowed 4 Divorced other than "nature vent, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) clerical office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ပ Raymond Philip Kenny Marion Agnes Holle and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print, 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 603 Wilgis Road Fallston, Maryland 21047 Mr. Thomas Slinkowski/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel – Bel Air 20c. Location - City or Town, State 1 ☐ Burial 2 😿 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 21. Signature of Funeral 22. Name and Address of Facility
Peaceful Alternatives Funeral and Crenation Center, P.A.
2325 York Road Timonium, Maryland 21093 ervice License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute respiratory disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence or Physician/Medical Examin cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð hypertension Severe pulmonary 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 To 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed? Yes 2 12 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 4 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my informacy, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Win kles D6342D June 2,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sid Kharal, 500 upper chesapeake Dr. Bel ATT, MD 21014 31. Date filed (Month, Day, Year)
JUN 0 4 2012 Registrar

amend #14, per fh, g928 6-19-12 sm Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State Amend Item 2 Registrar 1. Decedent's Name (First, Middle, Las.		and / Dep 28,06/04 e	artmen 12012 Hificate	t of Health and of Death		Hygiene Reg. No.	201	2 7506
Physic /Medi	cal	4a. Facility Name (If not institution, give	1	Sn	1 + 1 4b. City,	h	/VC	nth Day Uy 13	Year 2012 County of Dea	3. Time of Death 17.44 PM
Exami	ner	Johns Hopkins Bayvie	w Medical Cent		Baltir	more				
Funeral Director		5. Social Security Number 6. Security Number 217-70-0307 Usual Residence of Decedent	X M 2 □ F 7. Age (In y. 54	rs. last birthday) Yrs.	If Under Months		Min. (Mo	e of Birth <i>nth, Day, Year)</i> 1–21–19 <u></u>	Co	thplace (State or Foreign untry) TH CAROLINA
e Maryland Ba-f show iffied at	Director	10a. State 10b. County MD •	10c.	City, Town or Lo		TIMORE				10d. Inside City Limits 1 Yes 2 No
with th		10e. Street and Number	DERM		10f. Zip-			10g. Citi;	zen of What Co	
Nore, Maryland 21215-0036 ages 1 and 2 should be filed within 72 hours after death with the Maryland nt of Heath and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	524 S. LEHIGH ST 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Deced If Yes, spec	21224 Jent of Hispanic Origin Jent of Hispanic Origin Jent of Hispanic Origin Specify:	n? (Specify Yes Puerto Rican, e	s or No-		rican Indian,
21215-0036 d within 72 hours aft giene. rr then "natural", or the Medical Examir	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation	ation (Give kind of work done during most of working						/Industry
Maryland 2 d 2 should be filed v th and Mental Hygie 27 is marked other i traumatic event, th	To Be Co	17. Father's Name (First, Middle, Last) UNKNOWN				18. Mother's	s Name (First,	Middle, Maiden		
e, Maryla 1 and 2 should Health and Men lem 27 is marke other traumatic		19a. Informant's Name/Relationship (7) ROGER D. SMITH	vpe. Print) BROTH			S(Street and Number of SNEWALL LA		Number, City o		
Baltimore, permit. Pages 1 ar Department of Hea Important: If item any injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	b. Place of Disponentery, cre ATLANTI	matory or o	ther place)	Date	20c. Lo 12 GLEN	cation - City or	
Baltimol permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licens		2	2. Name an		CHARLES		ILER &	SON, INC.
Physician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	ne cause on each line.			e of dying, such as ca	•			Approximate Interval Between Onset and Death
/Medical Examiner	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Hype Constant of the Due to (or as a constant of the Due to (or account of th	sequence of): $fends$	Sior					
760, te be executed ysician and he burial-transit	lical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a cons	sequence of):						
I Records, P.O. Box 687 The law requires that the death certificate the has been signed by the attending phy page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3	☐ Ectopic p ☐ Other (sp				23d. Date of de Month	livery Day Year
cords, P. w requires that the been signed by should be detailed.	þ	Part II. Other significant conditions co	entributing to death but not	resulting in the	underlying (cause given in Part I.	236		use contribute t	o the cause of death?
of Vital Records, Physician: The law requires the certificate has been signer ral director, page 2 should be	Completed						- _	a. Was an autopsy performed? Yes 2 XNo	prior to death?	utopsy findings available completion of cause of
of Vita Physician: this certifica	Be	25. Was case referred to medical examiner?	Hospital:			Other:	Death (Check			
Phys Phys r this c	<u>ا</u> ک	1 A Yes 2 □ No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		8c. Injury at	ng Home 5 [Residence scribe how injur	6 Other (Spe	cify)
Division of Vital Re To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page?	Certification:	1) Natural 5 Pending investigation 3 Suicide 6 Could not be determined	Work? 1 ☐ Yes 2 ☐ No , office	28f. Loc	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
Hospital o 4 hours aff Funeral Di tely filled ir		29a. Certifier 1 Certifying Phyone 2 Medical Examone)	vsician: To the best of my kiner: On the basis of exam	nowledge, deat	th occurred	at the time, date and p	place, and due	e to the cause(s)) and manner a d place, and du	s stated. ue to the cause(s)
To the within 1 To the comple	Medical	29b. Signature and title of certifier	and manner stated.	MN	1	License number	20	29d. Dat	te signed (Mon	
(5)		30. Name and address of person who								2012 .
St Regist	ate	31. Date filed (Month, Day, Year)	NAKINS 32. Registrar's Sig		,	494	o Easter	ii Avenue	z, Daium	ore, MD, 21224

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 8:03 PM 2012 June a Charles Shine /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death or Location of Death Examiner MD asmto more 8. Date of Birth (Month, Day, Year)
July 24, 1923 Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Min. Country) 1 XX 2 F Yrs. MD 219-16-5027 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, its Medical Examinar must be notified at 10a. State 1 ☐ Yes 2 ☐ No Director Anne Arundel Pasadena 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21122 USA 16 Spring Knoll Dr. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 □Yes 2XX No Specify: White <u>8</u> Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Martin Marietta 12 Machinist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Marie A. Gerstel John A. Shine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 285 Wilmore Dr., Middletown, DE 19709 Joyce Harding Sister 20b. Place of Disposition (Name of Grente Haven's or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of Important: If it any Injury or conce. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) June 7,2012 Crownsville Veterans Cem Crownsville, MD Name and Address of Facility
Fink Funeral Home, P.A. 21. Signature of Juneral Service Licenses MQ1148 426 Crain Hwy S., Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neumon disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has l irector, page 2 s autopsy performe 2 14No 1 □ Yes 1 □Yes 2 **N**o the Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide within 24 hours a To the Funeral I completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave, Baltimore, MD, 21229.

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day UOTYAJE 3:10 PM JUNE 5015 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIHORE - WASHINGTON MEDICAL CENTER GLEH BURHIE BOUNAASHUA Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min Director 233.30.8902 88 FEB 26, 1924 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director MD ANNE ARUNDEL **GLEN BURNIE** 1 Yes 2xx No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 604 OLD STAGE RD. 21061 USA death 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner AXX ed Forces?

1 Yes 2 No 0 1 Never Married 2 Married Black, White, etc. þ within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Specify. Completed Year or Dates. WW WHITE traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) MASTER MACHINIST U.S. GOVT. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ဨ DELBERT L. SLAYTON EDNA B. STEWART 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 JOSEPH L. SLAYTON SON 1163 BAYVIEW VISTA ANNAPOLIS, MD 21409 20a. Method of Disposition
1 ☐ Burial XX Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 4 Donation 5 Other (Specify) MDVETCEM CROWNSVILLE JUNE 6, 2012 CROWNSVILLE, MD 21. Signature of Funeral Services 22. Name and Address of Facility
FINK FUNERAL HOME P.A.
426 CRAIN HWY SW CLEN BURNIE, MD21061 K-GRECORY FINK M01148 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician 212932 BINEEKS Medical resulting in death) Examiner 3 MEEK? nuomo ug Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical certificate be Box 68760 yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, AKI, WITEMI, CAROTIO ENDARTERECTOMY 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an has autopsy page certificate Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 🔀 No ျ 1 🖾 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director;

completely filled in by the Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Quilomajos arigoras 40 D0065+1A JUNEIJJOIJ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GUILLERMO JOSE GIANCRECO BOI HOSPITAL DRIVE, GLEN BURNIE, MD 20161 State

DHMH 17 Rev 06-2011

Registrar

12-03617 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Willie Shell State of Maryland / Department of Health and Mental Hygiene 2012 17509 1- For State Certificate of Death Registrar Reg. No 1, Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Shell Month Willie Medical Examiner 0552 hrs May 11, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4 North Central Avenue Baltimore **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign 53 Days Country) Months Hours 03/23/1959 Director GA unk 1XX_M 2 F Yrs Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Randallstown MD 1 Yes 2XXNo or 28a-f show death with the Maryland Director 10e. Street and Number 10f. Zip Code 21233 10g. Citizen of What Country? 8803 Silina Rd. USA 238 Funeral 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, must be Armed Forces? 1XX Never Married 2 Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Yes Black mit. Pages I and 2 should be filed within 72 hours after partment of Health and Mental Hygiene.
portant: If item 27 is marked other than "natural", o ury or other traumatic event, the Medical Examiner is Yes 2XX No specify: Widowed Give Year 4 Divorced Specify \$ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Carpenter Carpentry ltimore, MD 21215-0036 10 17. Father's Name (First, Middle, Last)
Eugene Shell 18.Mother's Name (First, Middle, Maiden Surname)
Mae Bailey Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
268 Gates Ave. #3, Brooklyn, NY 11216 Krystle Shell / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State W. Arundel Crematory 06/01/2012 Odenton, MD Donation 5 Other Specify: permit. 21. Signature of Funeral-Bervice Licensee ²² Name and Address of Facility Bailey Funeral Home and Cremation Service, PA 4023 Annapolis Rd., Halethrpe, MD 21227 M01452 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line. Between Onset and Medical Death a. Hypertensive Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): n and I - transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial: transit Physician/Medical UNPENDED AMENDED P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of deliver 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Fetal death Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Division of Vital Records, Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? ✓ Yes 2 1 🗸 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: Other₄ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 1 🗸 Yes ၉ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 V Natural Pending Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 4 (Specify) Homicide 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. g 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E May 11, 2012 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Carol Allan, MD

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ STEADMAN LEE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE TOWSON MEDICAL CENTER Year If Under 24 Hrs Days Hours Min. Age (In yrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months **Director** 218-26-8435 83 1 □ M **XX** F 02/13/1929 Maryland fshow or 28a-f show notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2XX No Maryland Baltimore Timonium 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral USA 21093 2525 Pot Spring Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2XX No altimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: "natural" 3XXWidowed 4 □ Divorced White Year or Dates. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) EADMAN, MARY Elementary/Secondary (0-12) College (1-4 or 5+ Clerk Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leo Kreafle Mary Whalen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8115 G Yellow Pine Drive Ellicott City, Maryland 21043 Page 1 and 2 Thomas F. Steadman Bro-In-Law 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XXBurial 2 Cremation 3 Removal from State 06/08/2012 New Cathedral Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Jervice Lig 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc Alephan 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 5 MINUTES Medical Due to (or as a consequence of) Examiner HOUR Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury SPIRATORY that initiated events resulting in death) Last Due to (or as a consequence of physician Physician/Medical that the death certificate be Box 68760 the } attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy for in the past 12 months? 1 Yes 2 No 9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death the a 9 I Inknown Division of Vital Records, P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law certificate has autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 1 Yes 2 No Be 26 Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA within 24 hours after death. To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Yes Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 170

DHMH 17 Rev 06-2011

State Registrar 7601 OSLER DRIVE TOWSON, MARYLAND 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FABRICE CZARNĘCKI, M.D. 760.

32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 29 12:30P Physician/ SKIPPER **JOHN** WALTER III Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore 5631 Allender Rd White Marsh Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1961 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Funeral Days Hours May 31, 2012 Mary land Director 218-46-0453 50 1 **X**X/1 2 □ F Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location notified at Director 1 Tes 2 XXNo Maryland Baltimore White Marsh 10g. Citizen of What Country? 5 10e. Street and Number 10f. Zip Code items 23a or ner must be n Funeral 5631 Allender Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in LLS 14. Race - American Indian. 11. Marital Status Armed Forces? Examiner Black, White, etc. o 1 Never Married 2 XX Married þ within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2XXNo Specify Specify: "natural" Completed 3 Widowed 4 Divorced White Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Mechanic Heavy Equipment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ပ Marlene Virginia Preller John Walter Skipper Jr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other traconce. Wife Laurie Morgan Skipper 76 Olde Forge Lane Nottingham Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1XXBurial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Parkwood Cemetery 06/02/2012 Baltimore, Maryland 22. Name and Address of Fathitchell-Wiedefeld Funeral Home Inc nature of Funeral S nnis 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Covonary Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) 2008 Examiner Merosclero Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examil burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death signed by the at id be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 25 No 24a. Was an ovonav autopsy this certificate has ral director, page 2 Yes 25. Was case referred to medica filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 1 Nursing Home 5 Residence 6 \(\text{Other} \) Other (Specify, 1 Yes م 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After t 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

State

Registrar

Samaritan Hospital 5601 Loch Raven

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

509

(Month, Day, Year)

JUN 0 4 201

Morgan
31. Date filed/(Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2012 Month Physician/ Judia Thompson Lynn 24 рМ 2:24 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4357 Old Frederick Rd Baltimore Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 19541 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) VA 229-74-9951 Director 54 1 □ M 2 🖺 F Sept 18 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene.
The strain and the strain and the strain of the strain and the strain at the mental strain and the strain and th 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4357 Old Frederick Rd 21229 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 24 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ρ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Black Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Private 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Edward Thompson Luella Clark Bynum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4357 Old Frederick Rd Baltimore Md Larry E Bunch - Husband 21229 20b. Place of Disposition (Name of Mt. cemetery, crematory or other place)

Olivet Cem 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 (
Department of H
Important: If Its
any injury or ot 1 Burial 2 Cremation 3 Reproval from State June 4 ☐ Donation 5 ☐ Other (Specify) Washington DC 2012 cc025 21. Signature of Funeral Service/Licensee 22. Name and Address of Facility McLaughlin Funeral Home 2518 PA Ave SE Washington DC 20020 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. terval Between Onset and Death Immediate Cause (Final Priysiciani COLON disease or condition resulting in death) UNKNOWN Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated exact) Due to (or as a consequence of): siclan and e burial-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending physical for use as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Day been signed by the s should be detached 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an cate has l page 2 s autoosy certificate 1 Yes 2 No Yes 2 DNo of Vital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Horne 5 Residence 6 DOther (Specify) 2 No 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending To the Hoepital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the functions. Division 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated e and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) D0026327 5-24-2012 who completed cause of death (Item 23a) (Type, Print) Eutaw St. Baltimore MD, 2120 838N ouglas 32. Registrar's Signature State Registrar

2,24pm

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			For State of Maryland	/ Department of Hea	, ,	iene
			Registrar	Certificate of Dea	ath R	eg. No. 2012 75 3
ı	Physicia Medic		1. Decedent's Name (First, Middle, Last) HERMAN THOMPS	ON	2. Date of Deat Month MA	h Day Year 3. Time of Death 3. 'YO A M
	Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Loca	ation of Death	4c. County of Death
7	<i>)</i>		HOWARD COUNTY GENE	PAL COLL	OMBIA	HOWARD
į,	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. lass 220−30−8857 1 🖾 M 2 □ F 78		Juder 24 Hrs. 8. Date of Birth (Month, Day, Jan. 22)	Year) 9. Birthplace (State or Foreign Country) MD
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	yland -f sho ed at	cto		Town or Location		10d. Inside City Limits
	ne Marylar or 28a-f sh notified	Jie	MD Howard	Woodbine		1 Yes 2 X No
	72 hours after death with the Maryland "natural", or items 23a or 28a-f sho fedical Examiner must be notified at	Funeral Director	15401 Frederick Road	10f. Zip Code		0g. Citizen of What Country? USA
	ath w	nue	11. Marital Status 12. Was Decedent Ever in U.S.			14. Race - American Indian,
တ	er de or ite	by F	V Armed Forces?	If Yes, specify Cuban, Me	sic Origin? (Specify Yes or No- exican, Puerto Rican, etc.)	Black, White, etc.
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5-0	e filed within 72 hour tal Hygiene. ed other than "natu event, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during		16b. Kind of Business/Industry
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anc		10 B	17. Father's Name (First, Middle, Last) Victor Thompson	18.1	Mother's Name (First, Middle, M. Luella Miller	
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, Maryland 21215-0036	permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		19a. Informant's Name/Relationship (Type, Print) Mr. H. Lee Thompson (Son)	19b. Mailing Address (Street and N 15 Rossevelt Rd.	., Eldersburg,	City or Town, State, Zip Code) MD 21784
Baltimore,	e 1 ar of 14.			ce of Disposition (Name of netery, crematory or other place)	Date	20c. Location - City or Town, State
<u>ä</u>	. Pag iment tant: jury c		4 Donation 5 Other (Specify)	st Lawn Mem. Gard	dens 5/25/12	Marriottsville, MD
3ali	permit Depar Impor any in once.		21. Signature of Funeral Service Licensee	22. Name and Address of F		ERAL HOME & CHAPEL, PA
	⊕ C C = @ O		Duan CHarglet MO0764		Sykesville, MI	21784
			23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Immediate Cause (Final	920	AND THE CONTRACT OF THE CONTRA	Approximate Interval Between Onset and Death
	Physician/ Medical		disease or condition		MOLTA	Onset and Death
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, Box 6876	tificat ng ph as tl	Me	IF FEMALE:			
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	the at	/sic	1 Yes 2 No 4 Pregnant at time of dea 9 Unknown 9 Unknown	ath 5 Other (specify)		Month Day Year
P.0.	ss that the death certificate igned by the attending phys be detached for use as the	Ph	Part II. Other significant conditions contributing to death but not result	ing in the underlying cause given in	Part I. 23e Did tob	acco use contribute to the cause of death?
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of V	r this	은 :a	27. Manner of Death 28a. Date of injury 28	R/Outpatient 3 □ DOA 4 1 Bb. Time of 28c. Injury at	Nursing Home 5 ☐ Resider 28d. Describe how	
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isio	Atter	ŧ	3 Suicide 6 Could not be 28e. Place of Injury - At home	e, farm, street, factory, office		eet and Number or Rural Route Number,
Division of Vital Records,	ral or rs after al Dir	Ö	building, etc. (Specify)		City or Town,	State)
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medical Certificate:	29a. Certifier (Check 1 ☐ Certifying Physician: To the best of my knowled 2 ☐ Medical Examiner: On the basis of examination a	ge, death occurred at the time, date	e and place, and due to the caus	se(s) and manner as stated.
	the hin 24		only one) 3 Certifying Nurse Practitioner: To the best of my	knowledge, death occurred at the time	ne, date and place, and due to the	cause(s) and manner as stated.
_	vit No Cor		29b. Signature and title of certifier	29c. License numb		d. Date signed (Month, Day, Year)
			> K Sh lattra MD		564539	
_			30. Name and address of person who completed cause of death (Item 2:	Ba) (Type, Print) EDAR LANG	E, COLUMB	IA, MD
	Stat Registra	e ir	30. Name and address of person who completed cause of death (Item 2: S. Y. A. N. O. M. O. F. V. 1. 5.7.5.5. C. 31. Date filed (Month. Day, Year) 32. Registrar's Signature 3. 1. 2. 32. Registrar's Signature 3. 32. Registrar's Signature 3. 33. Registrar's Signature 3. 34. Registrar's Signature 3. 35. 35. 35. 35. 35. 35. 35. 35. 35.	park		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death 3:38 Physician/ vorace immons 201 Medical a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Himore Secours N/A 1 Year If Under 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** Carolina 1**X** M 2 □ F Months Hours 03^M70^h1^D7^x1^x9ⁿ44 247-76-7652 68 Director Usual Residence of Decedent show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at by Funeral Director 28a-f 1 X Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 permit. Page 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must har 2525 Hollins St. 21223 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2x Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 🗌 Widowed 4 🗎 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 10th Grade College (1-4 or 5+) Powder Coater Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Bobby Timmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna Timmons(wife) 2525 Hollins St., Baltimore, MD 21223 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 🔀 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) Western Star Cem. 06/02/12 Baltimore, MD 4 Donation 5 Other (Specify) ਰੋਰੇਡਵਾਮੀਰੀਜ਼ਿੰ•ਾਂ Brown jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD21217 21. Signature of Funeral Service License Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis Physician/ disease or condition resulting in death) Medical as a consequence of) **Examiner** intection Wound Sequentially list conditions Examiner it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Dav Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 Pending 1 Yes 2 🗌 No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2. only one 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) 2012 Name and address of person who completed cause of death (Item 23a) (Type, Print) 2000 State

DHMH 17 Rev 7/2009

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death May 23, Physician/ 2012 5:45 PM M Darryle Deane White Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick 6001 Mountaindale Road Thurmont Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Hours Min (Month, Day, Year) Director 230-80-1712 1 🛛 M 2 🗆 F 06/13/1955 Virginia 56 works should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at Director 1 Yes 2 X No MD Frederick Thurmont 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 6001 Mountaindale Road 21788 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or iter Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates 27 is marked other than "natu traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Transportation Manager Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Marchetti Charles White Helen Oliver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 is permit. Page 1 and 2 2...
Department of Health a Important: If item 27 in ite 6001 Mountaindale Road, Thurmont, MD 21788 Tammy Higgins / Spouse 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 06/04/2012 | Hanover, Maryland Anatomy Gifts Registry 21. Signature of Funeral Ser Land censee 22. Name and Address of Facility Anatomy Gifts Registry Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ ũ disease or condition Medical resulting in death) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death ate has been signed by the a page 2 should be detached f 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☑ No 1 Yes 2 No 25. Was case referred to medical examiner? completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 2 No မ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending after death. Director: Af Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day. Year. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Costello M.D., 1561 Oppossumtown Pike, Frederick, MD 21702 31. Date filed (Month. Dav. Year) State

DHMH 17 Rev 06-2011

Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funaral Director: After this cartificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

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	5. Social Security Number 6. Sex / 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs	8. Date of Birth 9. Birthplace (State or Foreign								
	217-89-9137 12 M 24 89 Yrs.	10 01/10/1923 SRI LANKA								
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits								
5		1 ☐ Yes 2 No								
ect	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?								
	115 SEMINARY AVENUE 2109									
Funeral Director	11. Marital Status 2. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian,								
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	EIEN WIJERATNE / DAUGHTER / 15 W. SEMINAR AVE 20a. Method of Disposition 1 Burial 2 Octemation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State								
	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) METRO CREMATORY INC.	02/2012 BALTIMORE MARYLAND								
	21. Sign are of Funeral Service Licensee 22. Name and Address of Facility 16.	02 2012 BALTIMORE MARY AND EDERRICK C. JONES FLAT PA.								
1	Merrif Co Jan 4611 PARK HOTS, A	UE. BALTIMORE, MARY JANG								
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	Approximate Interval Between								
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Be	25. Was case referred to medical 26. Place of De examiner?	ath (Check only one)								
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flca	3 Suicide 6 Could not be 28e. Place of Injury - At home farm street factory office	28f. Location (Street and Number or Rural Route Number,								
ert	4 Homicide building, etc. (Specify)	City or Town, State)								
Medical Certification:	29a. Certifier 1 Certifying Physician: To the best of my knowled to death occurred at the time, date and trace	e, and due to the cause(s) and manner as stated								
edic	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	urred at the time, date and place, and due to the cause(s)								
Σ	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)								
2	Deputy D18667	May 29, 2012								
	30. Name and address of person who completed cause of d ath (Item 21a) (Type, Print)	May 29, 2012 wille, Md 21093								
	31. Date filed (Month, Day, Year) 32. Registrar's Signature.	210,11e, Ma 21043								
ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature									
rar										

DHMH 17 Rev 1/2001

Regis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 757 A M Williams 2012 Voh Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospita /A HOPKINS altimore Johns 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Hours Min Country Director 1 X M 2 □ F -3 6 Usual Residence of Decedent or 28a-f show f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status Was Decedent Ever in U.S. 14. Bace - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married þ Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Black Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College [1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental F 1 and 2 should be fill of Health and Mental item 27 is marked 9 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mother Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) 2012 e of Funeral Service Licensee ignati 22. Name and Address of Facility 21202 Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Approximate Interval Between ate Cause (Final Onset and Death Priysician Stage IV neuroblastoma or condition Medical g in death) Due to M as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) and Due to (or as a consequence of): resulting in death) Last burialattending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the 33 IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death Ectopic pregnancy for in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death Yes 2 No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 💢 No မ 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28c. Injury at work?
1 Yes 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) Res-00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Posin Fatusin 2128 1800 Orleans Street Baltimore 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 29/2012 Williams Emma Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death N/A Baltimore 421 Gwynn Ave. Birthplace (State or Foreign Country)
 MD Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days 1 🗆 M 2 🖾 F 3 157 1931 217-26-6486 Director 81 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland aţ Director be notified N/A Baltimore MD 28a-f 1 Yes 2 No 10f. Zip Code 21 229 10e. Street and Number 10g. Citizen of What Country? 23a or Funeral 421 Gwynn Ave. USA must of Health and Mental Hygiene. item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian, 11. Marital Status Black, White, etc Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black 3 ☒ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) March Funeral Home Elementary/Seconday (0-12) College (1-4 or 5+) n and Mental Hygiene. Flower Shop N/A Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thelma Thompson ဂ္ James Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4305 Star Circle Randallstown, MD 211333 Cheryl Moody-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Memorial Pk. 20a. Method of Disposition 20c. Location - City or Town, State ō Important: If it any injury or o 1 Surial 2 Cremation 3 Removal from State 6/4/2012 Randallstown, 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Balt imore, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval B tween
et a Death Immediate Cause (Final Inds the Prysician/ disease or condition resulting in death) Medical Due to (or as a consequen-Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequent e of ending physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregr 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the secompleted filled in by the funeral director, page 2 should be detached to 9 Unknown 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 🗹 2 No 25. Was case referred to examiner? Be 26. Place of Death (Check only one) 2 7 No မှ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Yes 2 No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of cert 29c. License number 29d. Date signed

State Registrar 30. Name and address of

31. Date filed (Month, Day,

Year

JUN 0 4 2012

DHMH 17 Rev 7/2009

leted cause

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2012 State Registrar Certificate of Death . Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Month 2012 Leona Oneida Ward May 1:07P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Country Care Assisted Living Westminster Carroll If Under 6. Sex **Funeral** 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Director** 216-14-6445 1 🗆 M 2 🕱 F 89 Mar. 13, 1923 Maryland Usual Residence of Decedent 28a-f show 10a. State with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No Maryland Carroll New Windsor 23a or 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 2411 Old New Windsor Pike 21776 items ? and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Armed Force Black, White, etc. , 0 þ 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. "natural", Completed 3 Widowed 4 Divorced White Health and Mental Hygiene. tem 27 is marked other than "natu ther traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 <u>supervisor of packing dept</u> shoe factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Roy Hiner Mamie Humbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronnie L. Staub/ son 1489 Western Chapel Rd. item 2 New Windsor, MD 21776 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, permit. Page 1 a
Department of IImportant: If ite
any injury or ot 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pleasant Valley Cem. 6/4/2012 Pleasant Valley, MD 21. Signiture of Funeral Service Licensee 22. Name and Address of Facility Hartzler Funeral Home, P.A. 310 Church St. New Windsor, MD 21776 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician ! JE AST Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Dua to (or as a consequence of). cause. Enter Underlying attending physician and for use as the burial-transit Exami Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregna Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year the a signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by pe Records, Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available 24a. Was an After this certificate has autopsy prior to completion of cause of death? Physician: The 1 Yes 2 No 1 Yes 2 No Division of Vital upletely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) assisted living 1 🗌 Yes 2 INO မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 A Natural work? 5 Pending death. Accident 2 No Investigation within 24 hours after deatl To the Funeral Director. 6 Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatur nd title of certifier completed cause of death (Item 23a) (Type, Print) enter St. Westmin MD

Registrar

State

amend #1,per PHY, 20b,per fh, g928 6-4-12 sm Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Michelle L. Werrell 2. Date of Death Physician/ Month Year 5 Michell 1700Hr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1500 Lanhorn Ct.Apt.lA Baltimore ni 1a 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Feb. 23, 1955 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 1 🗆 M 2 🖵 F Hours Director 216-62-6490 57 Usual Residence of Decedent 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a, State 10c. City, Town or Location 10d, Inside City Limits Director be notified or 28a-f 1 Yes 2 No MD Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? items 23a oner must be Funeral 1500 Lanhorn Ct.Apt.lA 21202 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give 'natural", or by 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Specify: Completed Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Hamilton Nursing item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the 10th House Keeping home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Beatrice Johnson James M. Spencer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1118 N. Bond St. Balto, Md. 21213 Ronda M. Sample (daughter) 20c. Location - City or Town, State Date**4**, 20 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If it any injury or o Green Mount Cremationy or other place)

Green Mount Cremationy 1 Burial 2 Cremation 3 Removal from State Balto, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Calwin Adbess of Schuggs Funeral Home 21213 Preston St 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Cardiovascular Ph_sician disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit atrial Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical ardioni Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year Unknown 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Kidney discase 1 Yes 2 No 3 Probably 4 Unknown hepatitis C 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗌 No 1 🗆 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: Other: ္ဝ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No I **Director;** A Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 To the F 30. Name and address of person 🛶 o e of death (Item 23a) (Type, Print) 1000 EBMC Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#6perFH, G928, 6/6/2012, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ James Cyrill Young 16:020 Medical Town, or Location of Death ty Name (if not institution, give street and number) 4c. County of Death **Examiner** altimore N/A f Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 214-62-8122 Months Hours 1 X M 2 X **Director** 12/11/1955 Maryland Yrs. 56 or 28a-f show notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1X Yes 2 No Baltimore N/A MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a o with 1 Funeral U.S.A. 4414 BelAir Rd. 21206 filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Force 1 X Never Married 2 - Married Yes þ 2X No Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4 or 5+) the Construction Carpentry Self Employed 12th Grade permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other t Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Chelsea F. Young Cyrill Williams other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3212 Nerak Rd., Baltimore, MD 21208 Bernadette Thomas(sister) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other pl King Mem Park injury or 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 06/01/12 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 3 dsephdd As of Brown Jr. Funeral Home PA of Funeral Service Licensee any in MD21217 2140 N. Fulton Ave., Baltimore, ine Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Upper disease or condition resulting in death) Medical Examiner Hepatorellu Sequentially list conditions Examine Due to (or as if any, leading to immediate cause. Enter Underlying Hepub b's or Attending Physician: The law requires that the death certificate be executed QU~ Cause (Disease or injury signed by the attending physician and dbe detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death g Unknown Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page death? Yes 2 N 1 Tes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital 26. Place of Death (Check only one) Be Hospital Other: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pendina within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident Investigation 6 Could not be 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ٥, Kumei ~ 2-6618 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Kumer, 2009 Caron 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $^{\text{Day}}2012$ Month Doris В. Avery May 14, 6:25 РМ Medical a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 0 ct • 9, 1923 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 237-24-7102 1 M 2 XF Yrs North Carolina Director 88 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Silver Spring PG 1 ☐ Yes 2 1 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3142 Gracefield Road, #316 20904 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. White þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary USPS Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ Walter Raleigh Briley Catherine Rogerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth B. Winstead/Niece 119 North Eastern Street, Greenville, NC 27858 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Gate of Heaven Cemetery Cemetery 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State May 4 ☐ Donation 5 ☐ Other (Specify) 2012 Silver Spring, MD Signature of Funeral Service Licensee Francis Adjess Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ S pirator disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner estive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Fibrillastin 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy To the nospone.

within 24 hours after death.

To the Funeral Director. After this certificate I 1 Yes Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 2 X No 1 Yes Impatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 28a. Date of injury (Month, Day, 27. Manner of Death 28b. Time of 28c. Injury at 28d, Describe how injury occurred Natural 5 Pending injury work? 2 🗀 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗆 Homicide determined City or Town, State Hospital Medical 29a, Certifier retifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the I 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

7

Brian

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MI

9901

Medical

29d. Date signed (Month. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 7:45 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Silver_Spring Montgomery 3305 Ewood Lane 9. Birthplace (State or Foreign Country) 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs 8. Date of Birth 9/6/1922 1 M 2 KF Hours Yrs **Director** 437-36-7103 89 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director notified 1 Yes 2 No MD Montgomery Silver Spring 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 13305 Ewood Lane 20906 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc ģ "natural", or 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: 3√2 Widowed 4 □ Divorced Completed Black Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working r than the M life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8th Homemaker Homemaker ed other event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If item 27 is marked or any injury or other traumatic ever once. ၉ Lover Woods Jemmie Mae (Holmes) Woods 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13305 Ewood Lane, Silver Spring, MD 20906 <u>Diane A. Ravnor/daughter</u> 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Riley Military 5/22/2012 Ft. Riley, Kansas 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Snowden Funeral Home Signature of Funeral Service 246 N. Washington St., Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician! a Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Systemic sclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) s the burial trust Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death Month Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ۵ Congestive heart failure Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has page 2 s performed? Coronary artery disease 1 Yes 2 No Yes 2 X No Division of Vital 25. Was case referred to medical the funeral director. Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 \(\sum \) Nursing Home \(5 \) Residence \(6 \sum \) Other (Specify) ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury work?
1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 - Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 To the within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 190-246 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8901 Wisconsin Avenue Patrick O'Malley.Walter Reed National Medical Ctr. Bethesda. MD 20889 led (Month, Day, Year) 82. Registrar's Sign State 7 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 39 Victor D. Baker Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Western MD Regional Medical Center Cumberland If Under Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days (Month, Day, Year) November 19, 1943 Director 68 Maryland 219-44-1042 1 X M 2 🗆 F Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director must be notified 28a-f 1 X Yes 2 No Maryland Allegany Frostburg 10e. Street and Number 252 Shaw Street ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a U.S.A 21532permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc or . þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White "natural" Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I and a since of the state of t Elementary/Secondary (0-12) College (1-4 or 5+) Inspection Liquor Inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည **Elosie Hawkins** Charles Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21532-Maryland Susan S. Baker 252 Shaw Street Frostburg 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o nent of 1 Burial 2 Cremation 3 Removal from State Cumberland Crematory May 17, 2012 Cumberland Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lie 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 olin Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 SE IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months? Pregnant at time of death 2 No 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

LEREBRY INFRACTION, VPPERBY 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should FOU ENDUSTHROMBOSIS 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death?
1 Yes 2 No 1 Yes 2 certificate Be 25. Was case refe examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) filled in by the funeral Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury Investigation within 24 hours after death

To the Funeral Director, completely filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one tore and title of certifie 2 nd address of person who completed cause of death (Item 23a) (Type, Print) Name umberLANd egistrar's Signatu State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 17525 State of Maryland / Department of Health and Mental Hygiene John Burtner 1- For State Certificate of Death Rea, No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ May 18, 2012 1809 hrs Burtner John Joshua **Medical Examiner** 4a. Facility Name (if not institution, give street and number) c. County of Death 4b. City. Town, or Location of Death Washington Hagerstown Meritus Medical Center 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6 Sev **Funeral** oreign Country) Maryland Months Days Hours June 4,1946 Director 65 215-74-8231 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10a State 10b Count 10c. City, Town or Location 1 Yes 2 No Williamsport permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Maryland Washington Director 10f Zip Code 10g. Citizen of What Country? 10e. Street and Numbe USA 11014 Kemps Mill Road uneral 14 Race - American Indian Black 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specity Yes or No-11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married Yes White 1 Yes 2 No specify: if Yes, Give Yeer Specify: 3 Widowed 4 Divorced ≦ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) ARC Group Home Laborer 8 0 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kefauver Lena Samuel J.W. Burtner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13707 Rockdale Rd. Clear Spring, MD 21722 George Burtner 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Hagerstown, Maryland Hagerstown Crematory 5-22-2012 4 Donation 5 Other Specify 22. Name and Address of Facility Osborne Funeral Home P.A. Signature of Funeral Se ine License 425 S. Conococheague St. Williamsport, MD 21795 Part I. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line (Madical Death a. Choking on food bolus Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Records, P.O. Box 68760, The law requires that the death certificate be executed Physician/Medical x AMENDED 28b, per me, g928 6-25-12 sm UNPENDED attending physician or use as the burial IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delive 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Dav Year Live birth 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed be be deta ۾ 1 Yes 2 No 3 Probably 4 Unknown seizure disorder, mental retardation Completed s been s 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy certificate has performed death? Yes 2 ✔ No 1 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical the Hospital or Attending Physician: Be of Vital Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other this 1 Yes 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work' After 27. Manner of Death Certification: Subject choked on food while eating May 18, 2012 Natural Division 1 Yes 2 V No 5 Pending unknown P.M death. the 2 🗸 Accident in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. after 6 Could not be Suicide or Town, State) 820 Florida Avenue , Hagerstown, MD e Funeral Di letely filled in (Specify) Group Home 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b, Signature) and title of certifie O.C.M.E. May 19, 2012 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Laron Locke MD.

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

31. Date filed (Month Day)

ORIGINAL

32. Redistrar's Signature

COME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month ^{Day} 2012 Physician/ Bittinger 1:40 PM William May Forrest Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett Dennett Road Manor Nursing Home Oakland 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 1 X M 2 □ F **Funeral** Days Months Hours 1 1 / 1 2 / 1 9 3 1 Director 220-28-9238 28a-f shov 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Examiner must be notified at Director 1 🗆 Yes 2 🔀 No Oakland Garrett MD 10e Street and Number 10f. Zip Code 10a, Citizen of What Country? 5 U.S.A. Funeral items 23a 21550 197 Waterwheel Road death \ Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. ō 1 Never Married 2 Married þ 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: White "natural", Completed 3 X Widowed 4 Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry if, Page 1 and 2 should be in Page 1. and 2 should be in Page 1. and 1. and Mental Hygens, satment of Health and Mental Hygens is marked other than "nr " andic event, the Med (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Stone Quarry Stone Cutter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bowers 2 Bittinger | Bertha 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 225 Waterwheel RD., Oakland, MD 21550 Larry Lipscomb/ Step-Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Bittinger Family 1 X Burial 2 Cremation 3 Removal from State Important: If any injury or once. Swanton, Maryland 5/16/12 4 Donation 5 Other (Specify) Cemetery 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Newman Funeral Homes P.A. Second St., Oakland, MD 21550 203 S. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each set and Death Immediate Cause (Final Ph, sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine If any, leading to immedia cause. Enter Underlying Cause (Disease or iinjury Due to for as a excaso some off use as the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last nding physician Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy atter in the past 12 months? Day Month Year 5 Other (specify) 4 Pregnant : 9 Unknown Pregnant at time of death signed by the a 1 Yes 2 L 9 Unknown P.O. or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has page 2 performed' 1 Yes 2 No 1 Yes 2-25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ျှ 1 🗌 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After iniury work? 1 ☐ Yes 2 ☐ No 1- Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner On the best of promiseing and/or inventional control of the promise of promiseing and/or inventional control of the promise of promise o Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of celtifie 306 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 311

Registrar's Signatu

Thomas Johnson MD

MAY 18 2012

N.

Fourth St., Oakland,

MD 21550

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05 Day 2012 Sylvia Belle Beeghly 2:00 РМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oakland Garrett Dennett Road Manor Nursing Home 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Birtripi Country) WV Min. Hours (Month Day Year) 12/07/1927 Director 203-22-2497 1 □ M 2 🔀 F 84 Yrs ir then "naturel", or items 23e or 28e-f show the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits deeth with the Maryland 10c. City, Town or Location Director 1 Yes 2 No Oakland Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21550 **USA** 695 Oakland Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 🛣 No f Yes, Give Year or Dates. 1 Never Married 2 Married Pege 1 and 2 should be filed within 72 hours efter ment of Health and Mental Hygiene. Fent: If Item 27 is marked other then "naturel", or lury or other treumetic event, I'm Medical Examilury or other treumetic event, I'm Medical Examilury or other treumetic event, I'm Medical Examil þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify 3 Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaking Homemaker 12 æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Sylvia Ann Winters Lee Davy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 D Street, Mt. Lake Park, MD 21550 Susan E. Gnegy / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Depertment of importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 5/16/2012 Oakland, MD Gortner Union Church Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Burdock-Fredlock Funeral Home, P.A. 21 North Second Street, Oakland, MD 21550 23a. Part . Enter the disease, or complications that caused the death. Do not en the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) After this certificate hes been signed by the ettending physician end funeral director, page 2 should be detached for use as the burial-trensit Exami Hospital or Attending Physicien: The lew requires that the deeth certificate be executed Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available pnor to completion of cause of 24a, Was an autopsy After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funerel Director: Afte completely filled in by the fun 1 Natural 5 Pending 1 Yes 2 🗌 No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) homas G. Johnson 311 North Fourth St., Suite II Oakland, MD 21550 31. Date filed (Month, Day, Year) State MAY 15 Registrar

DHMH 17 Rev 06-2011

		For State Registrar	State of Ma		d / Depa		Health and N	Mental Hy		2012	17528	
Physicia Medic	cal	1. Decedent's Name (First, Middle, L Edith	Julia		Cu	rrence		2. Date of De Month May 1	4 20		3. Time of Death 7:45 A M	
Examin	er	4a. Facility Name <i>(if not institution</i> , g. 14811 McMullen				4b. City, Town, o Cumbe:	r Location of Death rland		4c. Co	unty of Death All	egany	
Funeral Director		5. Social Security Number 234-14-3092 Usual Residence of Decedent		e (In yrs. la 93	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 02/21/	v. Year)	9. Birth Cour West	place (State or Foreign htry) Virginia	
28a-f show	Director	10a. State 10b. County	llegany	10c. City	, Town or Loc	umberlan	d				10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
ns 23a or 2 nust be no	Funeral Di	10e. Street and Number 14811 McMullen	Highway, S	W		10f. Zip Code	21502		10g. Citizer	of What Cour USA	ntry?	
Department of the lath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Armed Forces? 1 □ Yes 2 ☑ If Yes, Give Year or Dates.			H	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: White		
n "natu fedical	Completed	15. Decedent's (Specify only highest	Education grade completed)		(Give I	ent's Usual Occup	during most of work	ing	16b. Kind	of Business In	dustry	
giene. ner tha t, the N		Elementary/Seconday (0-12)		NOT use retired)			Inter	ior De	signs			
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Health and em 27 is n ther traum		19a. Informant's Name/Relationship Mona E. McKenzie		_	1481	McMulle	and Number or Rura en Highway	y, SW,	Cumber	land,	MD 21502	
tment of I		20a. Method of Disposition 1 🕅 Burial 2										
Important in any ir		21. Signature of Funeral Service Dice	ensee				ss of Facility Adi ur Street				Home, P.A.	
nysician/ Medical Examiner		23a. Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a c) sequence of): Approximate Interval Between Onset and Death Onset a										
/sician and e burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last b. Due to (or as a consequence of). c. Due to (or as a consequence of):										
g physi as the b		d										
by the attending phys ached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									ery Day Year	
ned b		Part II. Other significant conditions	contributing to death be	ut not resu	ulting in the u	nderlying cause giv	ven in Part I,				ne cause of death?	
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icate has r, page 2	Completed by	1) 4 4 (autor perfo 1 Yes	osy ormed?		mpletion of cause of	
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within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Certificate: 7	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat	28a. Date of injur (Month, Day	у	28b. Time of injury	28c. Injur work	y at	28d. Describe h			,	
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with Sol			eur N	D.			066150		May	14, 20		
nds		30. Name and address of person wh Muhammad Naee	o completed cause of dem, M.D., 6	eath (Item 25 K	^{23a)} (Type, P ent Av	enue, Cu	mberland,	Maryla	nd 2	1502		
Stat	e	31. Date filed (Month, Day, Year)	32. Registra	r's Signat	ure							

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		For State Registrar	State of Mar	ryland /		artment of tificate of		Mental Hy	•	201	2	175	20
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Medic Examin		4a. Facility Name (if not institution, 11302 Mexico				4b. City, Town, o	or Location of Deat	th	_	c. County of D	eath 11e		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Bir								Birthpl	ace (State or Fore y) Land	eign	
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vith the Ma 23a or 28a st be notif	Funeral Director	10e. Street and Number 11302 Mexico E				10f. Zip Code	21502		10g. C	itizen of What	Count		1140
after c al", or Examin	þ	11. Marital Status 1 ☐ Never Married 2 ☒ Marri 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates.		l If	Vas Decedent of H f Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)		14. Race - Al Black, W Specify:		c.	
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nd 2 shoul ealth and I m 27 is ma		19a. Informant's Name/Relationsh John Cole / Hus		19	b. Mailin	g Address (Street 02 Mexic	and Number or Ru o Farms	Road, Cu	er, City c Imbe	r Town, State, rland,	zip Ca MD	21502	
Page 1 a treet of H tant: If ite jury or oth		20a. Method of Disposition 1 ☐ Burial 2 🎛 Cremation 4 ☐ Donation 5 ☐ Other (S)	pecify)	cemete	ery, crem rlar		tory 05/2		Cu	ocation - City	nd,	MD	
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live Birth 2 4 Pregnant at ti	Fetal deat		Ectopic pregnan Other (specify)	су			23d. Date of Month		y Day Year	
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tal or Atte rs after der al Director ed in by th	al Certificate:	3 Suicide 6 Could n 4 Homicide determin			arm, stre	et, factory, office		28f. Location (City or Tov			Rural F	oute Number,	
the Hospi hin 24 hou the Funer	Medical	(Check 2 ☐ Medical Exonly one) 3 ☐ Certifying	Physician: To the best of my caminer: On the basis of exar Nurse Practioner: To the be	mination and/	or investi	gation, in my opini	on, death occurred	at the time, date a	and place	e, and due to th	ne caus	e(s) and manner s	stated.
\Q 5 6 \qquad		29b. Signature and title of certifier				29c. Licens DOO	e number 66439			May 21,			
XLS		30. Name and address of person w Blanche Mavro	omatis, M.D.,	th (Item 23a) 1250	(Type, Pi	illowbro	ok Rd, S	te 300,	Cum	oerland	i, 1	ID 21502	
State Registra	-	31. Date filed (Month, Day, Year) NAY 21 2012	Serve 32. Registrar's	Signature									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryla	_	artment of H		3 0	ene g. No. 20	12	17530
	Physicia		1. Decedent's Name (First, Middle Albert	Last) Dunning	2. Date of Death						
	Medic Examin		4a. Facility Name (if not institution, Golden Livin	give street and number)			Location of Death	1 0000	4c. County	of Death Legan	8:30 Р м у
	Funeral Director		5. Social Security Number 218–12–5935 Usual Residence of Decedent	6. Sex 1 🔀 M 2 □ F 7. Age (In yrs	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 03/712749	24	Count	lace (State or Foreign ry) Insylvania
	ryland -f show ied at	ctor	10a. State 10b. County		Sity, Town or Local Bedford	cation				10	0d. Inside City Limits
	ith the Ma 23a or 28a st be notif	Funeral Director	10e. Street and Number 493 Evitts C			10f. Zip Code 1552	22	10	g. Citizen of V USA	Vhat Coun	1 ☐ Yes 2 🔀 No try?
36	should be filed within 72 hours after death with the Manyland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", artitles and it is market or it.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	If Yes, Give	_ 1	Vas Decedent of Hi i Yes, specify Cubar	ecify Yes or No- Rican, etc.)		e - America k, White, e	tc.	
Maryland 21215-0036	nin 72 hours ne. than "naturs e Medical E	Completed	15. Deceder	Year or Dates. WWI t's Education st grade completed) College (1-4 or 5+)	16a. Deced	lent's Usual Occupa kind of work done d O NOT use retired)		ing 1	6b. Kind of Bu	W	hite ustry
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aryla	hould be and Ment s marke umatic e	To	Albert 19a. Informant's Name/Relationsh Susan L. VanMe	Dunning ip (Type, Print)	-	es, Sr. g Address (Street a					lubaugh
2	1 and 2 f Health item 27 other tu		Susan L. VanMe	1 20h	Place of Dispor	sition (Name of	1	Data 2	, MD		
Baltimore,	permit. Page 1 Department of Important: If it any injury or o once.	Î	1 X Burial 2 Cremation 4 Donation 5 Other (S			emorial Page	erk 05/18	3/2012	Cumbe	rland	
Ba	Departing any any once	3	21. Signature of Funeral Service L	ldast		404 Deca	tur Stree	et, Cumbe	rland,		21502
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VItai	ysician: is certifici director, I	To Be (25. Was case referred to medical examiner? 1 \(\sum \text{Yes} \) 2 \(\overline{\text{N}} \text{No} \)	Hospital:	T EB/Outpatien	Otho	r: A X Nursing Ha				- Inc
on of	nding Ph ath. :: After th e funeral		27. Manner of Death 1 Autural 5 Pendin 2 Accident Investig	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	at	28d. Describe how			
DIVISION	al or Atte s after des l Director d in by th	Certificate:	3 ☐ Suicide 6 ☐ Could in 4 ☐ Homicide determine	ot be 280 Place of Injury At I	nome, farm, stre	et, factory, office		28f. Location (Stre- City or Town, S		r or Rural I	Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 ∟ Medical E	Physician: To the best of my kno- kaminer: On the basis of examinati Nurse Practioner: To the best of I	on and/or invest	igation, in my opinio	 death occurred at 	the time date and	place, and due	to the caus	se(s) and manner stated
			29b. Signature and title of certifier	How	3-7-	29c. License	number	290	d. Date signed May 16	(Month, D	ay, Year)
	10 t		30. Name and address of person v Sunil K. Gup	ta, M.D., 625	m 23a) (Type, P Kent Av	rint) enue, Cur	mberland,	l Marylan	d 215	02	
	Stat Registra		31. Date filed (Month, Day, Year) MAY 16 201	32. Registrar's Sign	ature parke	/					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2215 Melva M. Chanev Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Western MD Regional Medical Center Cumberland Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Months Hours Director 1 □ M 2 🛣 F 92 May 12, 1920 Maryland 215-12-2213 Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director must be notified 28a-f 1 X Yes 2 No Frostburg Maryland Allegany 10f. Zip Code 10g, Citizen of What Country? ō 10e. Street and Number 64 N. Water Street Funeral 23a U.S.A. 21532items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Examiner Armed Forces? 0 þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White If Yes, Give Year or Dates "natural" Completed 3 ₩ Widowed 4 Divorced the Medical Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M6 Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Homemaker 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Mahalia Miller Adam Gibb Patterson Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21502-Maryland Sharon Diehl Daughter 1258 Vocke Road LaVale 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State May 25, 2012 Frostburg Maryland 4 ☐ Donation 5 ☐ Other (Specify) Frostburg Memorial Park Signature of Funeral Service 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nt and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) jo in the past 12 months Month Day Year igned by the at be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by HEIBNIUMTION, 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed page 2 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner Ambah 28a. Date of injury (Month, Day, 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Year) - Natural 5 Pending after death.

Director: Af 1 ☐ Yes 2 ☐ No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated w 0

Registrar
DHMH 17 Rev 06-2011

State

Combelland,

who completed cause of death (Item 23a) (Type, Print)

2500

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death , Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10:40 A M Physician/ 05/118/2012 Cecilia Alvarez Cornier Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's **Hyat**tsville 4207 Oglethorpe Street Apt#202 Birthplace (State or Foreign Country) If Under 8. Date of Birth 7. Age (In yrs. last birthday, **Funeral** Months Days Hours 1 □ M 2**X**X Director 583-13-6252 02/03/1959 PR 53 ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director Hyattsville Prince George's MD 1 X Yes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 4207 Oglethorpe Street Apt#202 20781 United States ral", or items? lld be filed within 72 hours after death v Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Puerto Maryland 21215-0036 1 X Yes 2 ☐ No Specify: SpecHispanic "natural", 3 Widowed 4 Divorced Rican Completed marked other than "natur matic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Homeland Security Elementary/Secondary (0-12) College (1-4 or 5+) Human ServicesSpecialist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Albalberto Alverez Amatilbe Cornier other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $_{
m Apt}$ 202 permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Ricardo Plaud/Husband 420 Oglethorpe St. Hattsville, MD 20781 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 05/24/12 Ponce, PR Donation 5 Other (Specify) La Piedad Ometery 22. Name and Address of Facility Funeraria - Stalom Memorial 1646 Paseo Villa VO. Sabaretas Ponce. PR Signature of Funeral Service Licensee Ponce, PR 00716 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Metastcha disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical certificate be IF FEMALE: Was deceded in the past 12 months 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Hospital or Attending Physician: The law requires that the death 24 hours after death. Pregnant at time of death be detached 1 ☐ Yes 2 E Division of Vital Records, P.O. signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No certificate has To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\sum \) No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 28b. Time of Certificate: 1 Natural 2 Accident 5 Pending Yes 2 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 Basil Ct.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 20 2012 Mary Cordell 1:41 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 18014 Sand Wedge Dr. Hagerstown Washington Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days 215-26-7781 **Director** 82 1 🗆 M 2 🔀 F Jan. 12, 1930 Maryland Usual Residence of Decedent 28a-f show 10c. City, Town or Location must be notified at Directo 1 🗌 Yes 2 🎦 No Washington Hagerstown ь 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **23**a Funeral 18014 Sand Wedge Dr. 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ral", or iten Examiner r Completed by 1 Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", 3 X Widowed 4 Divorced Specify: White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Steve Palkovitz Mary Bauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 and 2 s of Health item 27 Michael F. Cordell/Son 286 West Queen St., Chambersburg, PA 20b. Place of Disposition (Name of cemetery, crematory of other place)
Smithsburg Crematory 5/21/2012 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 🗌 Burial 2 ី Cremation 3 🗎 Removal from State Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 21742 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or complic that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cay MANUER Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ment his Medical for as a conse Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury death certificate be executed nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No lospital or Attending Physician: The hours after death.

uneral Director: After this certificately filled in by the funeral director, pa Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 🔀 No ည 1 Inpatient 2 ER/Outpatient 3 I Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🕅 Natural 5 Pending work? 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check To the I within 2 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse 29b. Signature and title of certific D0063718 mpleted cause of death (Item 23a) (Type, Print) Th)-Chuckia Tisdale MD 11110 Medical Campus Rd., Suite 143, Hagerstown, MD 21742 31. Date filed (Month State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death Physician/ 15 Day 2012 Year Month Jean Frances Clemens 2:15 рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Encore @ Turf Valley Ellicott City Howard Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Months (Month, Day, Year) Davs Hours 190-18-9104 Director 89 1 M 2 X F Yrs 04/22/1923 Texas Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Howard 1 Tyes 2 No Ellicott City 5 10e. Street and Numbe 10g. Citizen of What Country? must be Funeral 23a 10217 Burnside Drive 21042 United States items ; Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian ed other than "natural", or iter event, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 2 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 X Widowed 4 ☐ Divorced Completed Specify: White Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental ? 2 John Deusch Frances Marucheck 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 10217 Burnside Drive Ellicott City, MD 21042 Sheryl Clemens - Dulsky / 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crest Lawn Mem. 05/18/2012 Marriottsville, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Sign Fre of Funeral Service Licenses Manito 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Patt I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Retween Immediate Cause (Final disease or condition Onset and Death Pnysician/ DENENTI monetto Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease of Injury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of) signed by the attending physician Physician/Medical requires that the death certificate be Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ Live Birth 2 - Fetal death in the past 12 months? Month 2 XNo Pregnant at time of death 9 Unknown P.O. E Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ should be Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown Completed peen heart Failure 24b. Were autopsy findings available prior to completion of cause of death? ons 24a. Was an has page 2 autopsy performed certificate 1 Yes 2 No 1 Yes 2 🖳 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No Assisted ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Living 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the valse(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) upte NID Suite 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NO 6 9650 Sanhago corumbo 21045

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND#29dpcnMD, 5/18/12; EMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May Physician/ Annette K. Conison 2012 5:25 am Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington Rockville Montgomeru Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Days Month, Day, Director 286-14-6581 88 Ohio Usual Residence of Decedent or 28a-f shov 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 No Chevy Chase Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2808 Washington Avenue 20815 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify White "natural", Specify 3 X Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical! 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sculptor 12 Art 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Morris Kizner Dora Wartik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Goldman - Daughter 2808 Washington Avenue, Chevy Chase, Maryland 20815 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 05/18/2012 Judean Mem. Gardens Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Licensei Mung 11800 New Hampshire Ave., Silver Spring, 23d. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one caus n each line. Immediate Cause (Final Pnysician disease or condition resulting in death) Medical Examiner ELLITUS-TYPE 2 TES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 Month Pregnant at time of death After this certificate has been signed by the funeral director, page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) Waithin 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending Accident Investigation pleted filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date Money (Mont 8 Day, 12:012 18084 elleni? 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MONTROSE 31. Date filed (Month, Day, Year) State 7 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra MEND#23-IIperMD, 5/21/12; BMW, MbCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 1932 2072 Mikhail Chechik Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Suburban Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours (Month, Day, Year) 214-43-0103 **Director** 1 X M 2 □ F 79 May 23, 1932 Bela Rus Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location with the Maryland Director 1 🗆 Yes 2 💢 No Rockville Maryland Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20852 259 Congressional Lane, hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. White 3 Divorced 4 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working should be filed within 72 h h and Mental Hygiene. 7 is marked other than "n College (1-4 or 5+) Elementary/Secondary (0-12) Manufacturing Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Sofia Karolinsky Mark Chechik 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 42 Waddington Court, Rockville, Maryland 20850 Dmitriy Chechik - Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 05/11/2012 Rockville. Maryland 4 Donation Other (Specify) Menorah Gardens 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. I S 21. Signa 11800 New Hampshire Ave., Silver Spring, MD 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. Cardiomyopathy disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner End Stage Liver Disease Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury requires that the death certificate be executed Renal Failure and that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy jo in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛱 Unknown neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Aspiration pneumonia To the Hospital or Attending Physician; The law within 24 hours after death.

To the Funeral Director, After this certificate has E performed?

1 Yes 2 No Respiratory Failure 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No ဂ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No X Natural 5 Pending Accident Investigation completely filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature

Registrar
DHMH 17 Rev 06-2011

State

8600 Old Georgetown Road, Bethesda, Maryland \$0815

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signatu

M.D.

Rohatgi.

31. Date filed (Month, Day, Year)

2-03933		Please Type or Print in Black Indelible Ink. Ensu			egibl	e.			
Charles Michael		State of Maryland / Department of Health at 1- For State Certificate of Death	nd Mental H	ygiene		2.0		2	1752
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of D	Reg. No.			3. Time	of Death
Medical Exami		Charles Michael DeBow		Month May 23,	2012	Year		2015	5 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, of the Street Sharpsbur	or Location of Death			c. County of Washingt			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye		8. Date of		/DD/YYYY)		holace (S	state or
Director		219-11-0844 1X M 2 F 26 Yrs. Months Da					Foreign	n	ryland
		Usual Residence of Decedent		Juli.	ر و	1900			
w any		10a. State 10b. County 10c. City, Town or Location							de City Limits
ryland a-f sho t once	cto	Maryland Washington County Boonsboro 10e. Street end Number 10f. Zip Code	_		10a Cit	izen of Wha	nt Coun		
with the Maryland ns 23a or 28a-f sho be notified at once	Director	501 Elm Crest Avenue 21713			_	JSA	1177		
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must be notified at once	uneral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of H	lispanic Origin? (Sp			14. Race -		can Indiar	n, Black,
or ite	F	1 Yes 2 X No	an, Mexican, Puerto	Ricari, etc.)		White,			
us afte	ā	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 N N 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occup		ork done	16b.	Specify: Kind of Bus	Whi		
	etec	Elementary/Secondary (0-12) College (1-4 or 5+) Mo To 1	fe. DO NOT use reti					,	
5-0036 led within 72 hours a lygiene. other than "natura the Medical Examira	Completed	10				asonry	CO	ntra	ctor
215-0036 be filed within 72 mal Hygiene. rked other than "ent, the Medical.	Becc	17. Father's Name (First, Middle, Last) Charles James DeBow	18.Mother's Name			Surname)			
Z = 9 = 5		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Stre	Brenda eet and Number or R	SUE LA Rural Route N	OCKE lumber, C	ity or Town	State,	Zip Code	9)
nore, MD 21 ages I and 2 should nt of Health and Me t: If item 27 is ma other traumatic ev		Brenda Sue Howell - Mother 501 Elm Cre 20a. Method of Disposition 20b. Place of Disposition (Name of c	st Avenue	, Boor	ısbor	o, MI) 2	1713	
		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Rest Haven Cemet	emetery, 5.26	Date	20c.				
Baltimore, permit. Pages I a Department of He Important: If ite injury or other ti		4 Donation 5 Other Specify:			_ ~		•		yland
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/Medical Examiner	- 1	Immediate Cause (Final disease a. Alcohol and Narcotic Intoxic	cation					Detwee	Death
		or condition resulting in death) Due to (or as a consequence of):							
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e be ex	ğ	■ UNPENDED □ AMENDED 23a, 27, 28a-f, per me, g	928 0-3-12	Z SM	100	1.5.1(1	P. C.		
ox 68760, ath certificate be ex attending physician or use as the burial	an/N	past 12 months?	Ectopic pregna	ncy	23	d. Date of d Month		ay	Year
Box 68760, e death certificate by the attending physic ed for use as the bur	Physiclan/Medic	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown							
that the d		Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.	23e. Dio	tobacco	use contrib	ute to t	he cause	of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safer death. 11 Director: After this certificate has been signed by ted in by the funeral director, page 2 should be detach.	Completed by			1 🗆 ነ	'es 2	No 3	Proba	ably 4	✓ Unknown
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of Vil ing Physic After this	2	Tes 2 No		28d. Describ				Goorie	
ion trenditional feath.	atio		Yes 2 X No	unknow	m				
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Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be exhin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician npletely filled in by the funeral director, page 2 should be detached for use as the burial.		29a. Certifier		Sharps due to the ca			s state	d	
Division of 1 To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinic and manner stated.							,
E > F 0	Ž	29b. Signature and title of certifier 29c. Licen	nse number			Date signed		th, Day, Y	ear)
		produce M. hand JRy me. d.	.M.E. OGME		May	y 24, 201			
		30. Name and address of person who completed cause of death (ftem 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Balti	more Street, Ba	altimore, M	/ID 212	23			
	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature							
Regist	rar	HIN 11 4 ZUIZ CERNY F. T							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dowlan Genevieve Day 2012 Physician/ 6:30 A M May 20 Medical 4b. City, Town, or Location of Death Cumberland 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 316 S. Central Avenue Allegany 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🏋 F West Virginia 236-36-1626 90 1472371921 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Cumberland Allegany 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 Funeral 316 S. Central Avenue USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Saltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", ^{Specify}American <u>Indian</u> Completed 3 ¥ Widowed 4 □ Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Florence A William Edmondson Allen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 316 S. Central Avenue, Cumberland, MD 21502 19a. Informant's Name/Relationship (Type, Print) Jean Gensler / Niece 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State etery, crematory or other place SS Peter and Paul Cem 05/23/2012 Cumberland, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home. ignature of Funeral Şen 404 Decatur Street, Cumberland, MD 21502 Part LEnter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of heart failure. List only one cause on each line. terval Between Immediate Cause (Final Onset and Death Physician/ ALZHEIMERS DEMENTA disease or condition resulting in death) Medical Due to (or as a consequence of) at least Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) nding physician and use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Consent at time of death 5 Other (specify) nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year P.0. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Drompen SERVILLE Records, 1 Yes 2 No 3 Probably 4 Unknown Completed imperten sion 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate ha performed? Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Niece's 2 No Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Spec this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending injury Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completed filled in by the fun 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and the time, date and place, and the time date and place, and the time date and place. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0069419 May 21, 2012 30. Name and address of person who comple Carissa Vea, M.D., mpleted cause of death (Item 23a) (Type, Print)
., 1313 National Highway, LaVale, MD 21502 31. Date filed (Month, Day, Year) **ANY 21 2012** Fegistrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 05 Medical chen 4c. County of Death 4b. City, Town, or Location of Death Examiner 4a. Facility Name (if not institution, give street and number) n/a 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8 Date of Birth Country) WV **Funeral** May 3, 1931 Director 234-44-3966 1 □ M 2 □X 81 Usual Residence of Deceden 28a-f shov 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County ms 23a or 28a-f sho must be notified at Director Cumberland 1 XYes 2 No MD Allegany 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21502 110 Porter Street an "natural", or items ? Medical Examiner mus death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married 2 permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give white Completed 3 Nidowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the own home 12 homemaker of Health and Mental Hygie If item 27 is marked other ir other traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Sarah Spadafore John Spadafore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, MD 21502 Cumberland 26 N. Centre Street daughter Donna Monteleone t: If item 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Department of I Important: If its any injury or ot crematory or other place. 1 X Burial 2 Cremation 3 Removal from State 5/21/2012 MD Rocky Gap Veterans Cemetery Flintstone 4 Departion 5 Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA of Funeral Service Licenses Skinatu 108 Virginia Avenue: Cumberland, MD 21502 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ dissection of aceta Due to (or as a construence of) disease or condition resulting in death) Acute Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Be Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) signed by the at id be detached for 1 ☐ Yes 2 Ł g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 \square Yes 2 No 3 ☐ Probably 4 ☐ Unknown Hypotension 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending within 24 hours after death.

To the Funeral Director, A completely filled in by the fi 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifig 29d. Date signed (Month, Day, Year) 29c. License number CRNP 2 RH5325 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ADAM SHEELY ST Baltimore, m) 31. Date filed (Month, Day, Year)
MAY 22 2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ MITZI ALICE DeWITT o'S 2012 026M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Western MD Regional Medical Center Allegan umberlano Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min. (Month, Day, Year) 12/27/1931 Connecticut **Director** 80 041-28-3794 1 □ M 2 🗓 F permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State Director 1X Yes 2 □ No Cumberland MD Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21502 646 Lincoln Street 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give 152 15 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates. 53-154 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Bethel Hendley Gerard Harrington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 439 Washington St., Brookline, MA Laura Harrington / Niece Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
M.S.V.C. Rocky Gap 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 05/11/2012 Flintstone, MD 4 Donation 5 Other (Specify) Home, 21502 of Funeral Service 22. Name and Address of Facility Upchurch, Funeral 202 Greene St., Cumberland, MD 23a. Part 1. Enter the claese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ neurwin disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): -transit that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician a hed for use as the burial-Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: been signed by the attending should be detached for use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Day Year Month Pregnant at time of death Linknown g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has within 24 hours after death.

To the Funeral Director. After this certificate I completely filled in by the funeral director, pag 1 ☐ Yes 2 👿 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this confidence of the Funeral Director: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 Npatient 2 ER/Outpatient 3 DOA မှ 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 🔼 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10/11 ow becoke Rohit NIAL 31. Date file MAY 1 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 21 2012 Alberta-Lucille Davis 10:18 AM Doris Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 55 East Washington Street Apt. 109 Hagerstown Washington Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb 7 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2 🗓 F Days Hours Country)
Maryland Director 219-34-5070 1937 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10h County within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 55 East Washington Street Apt. 109 21740 U.S.A. items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner Armed Forces?
1 ☐ Yes 2 🛣 No
If Yes, Give Black, White, etc. "natural", or 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 X No Specify: 3 🗓 Widowed 4 🗆 Divorced Specify: Completed White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 10 Stitcher Manufacturing 12 should be filed wit lith and Mental Hygie 27 is marked other r traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Carmie Luther Netz Viola Mae Morrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Douglas S. Davis / Son 229 N. Cleveland Ave. Hagerstown, MD other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of IImportant: If ite
any injury or ot Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 05-24-2012 Boonsboro, Maryland Boonsboro Cemetery 21. Signature of Funeral Service Licens 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA 21713 7606 Old National Pike Boonsboro, MD calions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest dause of each line. ter the disease, or complice heart failure. List only one 23a. Part 1. Er shock, o Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Atherscherosis Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Cause (Disease or impry that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be Box 68760 as the t IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ be Division of Vital Records, or Attending Physician: The law requires Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a, Was an certificate has autopsy performe Yes 2 1 Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မှု 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred atural injury 5 Pending ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) ause of death (Item 23a) (Type, Print) 26 5 Hagerstown, Md. MI: A 600

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Docherty 8:40 PM Edward Daniel May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Garrett Oakland Garrett Co. Memorial Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Security Number 8. Date of Birth Funeral 6. Sex 1 XM 2 □ F Months Days Hours Min. (Month, Day, Year) /18/1925 **Director** 188-18-1232 Pennsylvania Usual Residence of Decedent 28a-f show 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27: is marked than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits Director 1 Yes 2 No Garrett McHenry MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21541 2697 Mosser Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 XMarried ð Maryland 21215-0036 1 Yes 2 TNo Specify Specify: Completed 3 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Manufacture Steelworker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lotti Cleaver Docherty John 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2697 Mosser RD., McHenry, MD 21541 19a. Informant's Name/Relationship (Type, Print) 2697 Mosser RD., McHenry, Carolyn Docherty/ Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Jefferson Memorial Park 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/21/12 Pittsburgh, PA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Newman Funeral Homes P.A. Miller St., Grantsville, MD 21536 179 23a. Part 1. Enter the disease, or complications that control the disease that control the dis Approximate Interval Between shock, or heart failure. List only one cause on each Immediate Cause (Final Onset and Death Physician. disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events -tran and Due to (or as a consequence of): resulting in death) Last the burial attending physician Physician/Medical certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death 2 No the g Unknown g Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions confributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 24 hours after death.

e Funeral Director. After this certificate has become filled in by the funeral director, page 2.3 autopsy death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) 6 \(\subseteq \text{Other} \) Other (Specify) 2 No 1 🗆 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: the Hospital or Attending 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical 1🕊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifie 29c. License number un 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Thomas Johnson MD 311 N. Fourth St., Oakland,
31. Date filed (Month, Day, Year)

NAY 18 2012

Augustian Signature

MD 21550

Amended item 5 per Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Funeral Director; cs State of Maryland / Department of Health and Mental Hygiene 2 05/29/2012 7543 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Edward Clarence DeWitt Medical 1850 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death Regional Medical Center 4c. County of Death Cumberlana MILGANY **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Director Hours 1 **K** M 2 \square F 85 July 8, 1926 tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Maryland death with the Maryland 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Maryland Garrett McHenry 1 Yes 2 X No 10e. Street and Number **Funeral** [10f. Zip Code 10g. Citizen of What Country? 45 Bumble Bee Rd. 21541 USA 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. 14. Race - American Indian, by Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after 1 Never Married 2 X Married Black, White, etc. Completed 3 Widowed 4 Divorced 1 Yes 2 No White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Post Master U.S. Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Division of Vital Records, P.O. Box 68760

12	Joseph C. DeWitt		Marry Ethol Correspond	
E I	19a. Informant's Name/Relationship (Type, Print)	19h Mailing Address (Charles	Mary Ethel Savage	
once.	Ruby DeWitt/Wife	P.O. Box 150	and Number or Rural Route Number, City or Town, State, Zip Code) MCHenry, MD 21541	
5	I □ Burial 2 □ Cremation 3 Removal from State	Place of Disposition (Name of cemetery, crematory or other place	Date 20c. Location - City or Town, S	tate
	4 Donation 5 Other (Specify)	ak Grove Cemeter	May 14, 2012 McHenry, MD	
ouce	21. Signature of Funeral Servica Lieogsee	P.O. Box 2	ss of Facility Newman Funeral Homes, P. 275, Grantsville, MD 21536	Α.
	23a. Part 1. Enter the disease, or complications that caused the de shock, or hear failure. List only one cause on each line.	ath. Do not enter the mode of dyin	g, such as cardiac or respiratory arrest	oximate
cai	Immediate Cause (Final disease or condition resulting in death)	tatic Lunc		rai Between t and Death
ner	Due to (or as a conse	quence of):		
ne.	Sequentially list conditions, b. Resource Library Reading to Institute to the light list of the	atory Fail	ure	
Examiner	cause. Enter Orderlying	•		
Ξ I	that initiated events resulting in death) Last c. Due to (or as a consecution)	quence of):		
dica	d			
/Me	IF FEMALE:			
Physician/Medical	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 Live Birth 2 Fe	tal death 3 Fetopic pregnance	23d. Date of delivery	
ysic	1 Yes 2 No 4 Pregnant at time of 9 Unknown 9 Unknown	death 5 Other (specify)	Month Day	Year
by Pi	Part II. Other significant conditions contributing to death but not re	sulting in the underlying cause give	on in Part I	
	u.	g was give	and the cause	
bet	71		1 ☐ Yes 2 ☑ No 3 ☐ Probably	4 🗌 Unknov
Completed			24a. Was an autopsy performed? 1 \(\text{Yes} \) 2 \(\text{No} \) 1 \(\text{Yes} \) 2 \(\text{No} \) No	of cause of
100 1	25. Was case referred to medical examiner? Hospital:		ce of Death (Check only one)	0
و: 1	1 Yes 2 No Hospital: 1 Inpatient 2 27. Manner of Death 28a. Date of injury	ER/Outpatient 3 DOA Other	4 Nursing Home 5 Residence 6 Other (Specify)	
Certificate:	1 Natural 5 Pending (Month, Day, Year)	28b. Time of 28c. Injury a work?	28d. Describe how injury occurred	
erii	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At homicide	ome farm street factory office	es 2 No	
0	building, etc. (Specify)	28f. Location (Street and Number or Rural Route N City or Town, State)	lumber,
Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of my know	edge, death occurred at the time,	date and place, and due to the cause(s) and manner as stated.	
	only one) 3 Certifying Nurse Practitioner: To the best of r	n and/or investigation, in my opinion, ny knowledge, death occurred at the	date and place, and due to the cause(s) and manner as stated. death occurred at the time, date and place, and due to the cause(s) and time, date and place, and due to the cause(s) and manner as stated.	d manner stat
	. (29c. License n	umber 29d. Date signed (Month, Day, Year)
8 3	O. Name and address of person who completed cause of death (Item	MP ROS	9384 5/12/12	_
+VA	DENISE K. BITTHER CRUP !	23a) (Type, Print) 2500 Willow	Gook Rd. Cumberland m	10
ate ³	1. Date filed (Month, Day, Year) NAY 1 6 2012			(3)
-2011		4		
		ORIGINAL		
		ONOTIVAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 16^a May Lillian M. D'Amico 2012 9:35 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shangri-La Assisted Living Ellicott City Howard Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Country) **Director** <u>162 22 3686</u> 1 M 2 XF 84 02-13-1928 PA or 28a-f show notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho. 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 X No MD Ellicott City Howard 10e. Street and Number 10g. Citizen of What Country? ral", or items 23a or Examiner must be 3325 Greenway Drive 21042 United States 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 ☐ Divorced Completed White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) ntal Hygiene. ed other than " event, the Mer Elementary/Secondary (0-12) College (1-4 or 5+) Sales Retail of Health and Mental Hygie item 27 is marked other other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Ralph Tocci Julia Bandini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marisa Horn/Daughter 2631 Wynfield Rd West Friendship, MD 21794 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Crest Lawn Mem. Gard 5-21-2012 <u>∺</u> 5 Department or Important: If any injury or once. Marriottsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. Thom allens 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final estive Heart Failure Onset and Death Physician | disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): and I-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a I for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Month 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 1 Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical the Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) As 5, to Live မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title o 29d, Date signed (Month, Day, Year) W D

State Registrar 30. Name and address

31. Date filed (Month, Day, Year)

(4215

of person who completed cause of death (Item 23a) (Type, Print)

(edas

7012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

#23a per Min FCHD TM 5/16/12

State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 9:55 A May Hazel Anna Mary Speak Finneyfrock Medical 4a. Facility Name (if not Institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Frederick St. Joseph's Ministries, Inc. Emmitsburg Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours MAY 18, 1917 Mary Land 94 218-05-7568 Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State notified at Director 1 X Yes 2 □ No Thurmont Maryland Frederick 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? ms 23a or must be n ò 21788 Funeral 12 Apples Church Road United States death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ō 1 Never Married 2 Married þ Saltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2X No Specify: If Yes, Give Year or Dates Specify: White "natural", 3 X Widowed 4 □ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) shoe manufacturing 9 Shoe Company Be 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) and Mental Fishers is marked o 2 MATILDA DELAPHINE SHOOK **CLYDE** NORMAN SPEAK, SR. NORA traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health : 21788 PAUL FINNEYFROCK / Son 48 Blue Ridge Ave./Thurmont, MD other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Department c Important: If any injury or once. 0 Blue Ridge Cemetery May 5,2012 Thurmont, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 104 E. Main St./ Thurmont, MD 21788 23a. Part 1. Enter the disease shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ an disease or condition Medical resulting in death) **Examiner** Equantially not our diffusion, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to or as a consequence of): burial-transit and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death ed by the a detached f Unknown signed by t Part II. Other significant conditions contributing 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 2 s has 25. Was case referred to medical the funeral director, 26. Place of the (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 2 No 횬 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Medical Certificate: 28d. Describe how injury occurred 28c. Injury at Natural iniury 5 Pending work?
1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) the Hospital Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and certifie 29d. Date signed (Month, Day, Year) 0018 Emmits burg 31. Date filed (Month 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Friend : 00 PM 17 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4146 Bear Creek Road Friendsville MD 21531 Me Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours (Month, Day, Year) 214-48-3188 Director 1 🗌 M 2 🗶 F 1942 Maryland 69 Oct. 11, show 10a, State 10c. City, Town or Location 10d Inside City Limits ms 23a or 28a-f sho must be notified at Director 1 Yes 2 K No MD Garrett Accident 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 21520 3677 Bear Creek Rd. USA death v "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black White etc. þ 1 Never Married 2 Married Yes 2 X No permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify Specify: White 3 Widowed 4 X Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) if Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Cashier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Elra Galen Resh Jessie Resh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara L. Friend/Daughter 8602 Mayaone St., Laurel, MD 20724 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State Important: If any injury or Country Side Crematory May 19, 2012 Davidsville, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Serv 22. Name and Address of Facility Newman Funeral Homes, P.A. censes umai P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease/or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) LAYS Medical Due to (or as a consequence of Examiner Sequentially list conditions, Due to lor as a consequence of cause. Enter Underlying Cause (Disease or injury Exami attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death 9 Unknown detached been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy performed? 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: ဂ္ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1. Natural injury 5 Pending Accident within 24 hours after death. To the Funeral Directort At Investigation filled in by the Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

only one 29b. Signature and title of certifie

31. Date filed (Month, Day, Year) MAY 18 2012

(Hem 23a) (Type, Print)
DO 69 Wolf Aenes Drive Oakland WD

426154

29d. Date signed (Month, Dav. Year)

the

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/illiam Kenneti		1- For State Registrar	ate of Maryla	•	rtment c		nd Menta	I Hygiene	Reg. No.	
Physici Iedical Exam		Decedent's Name (First, Midd William K		ir				Month May 25,	Day Year	3. Time of Death 1339 hrs
		4a. Facility Name (if not institution 28 Middle St Apt 2	n, give street and nu	imber)		4b. City, Town, o		eath	4c. County of De	ath
Funeral Director		5. Social Security Number 216–96–8463	6. Sex	7. Age (In yrs. la		If Under 1 Ye Months Da		Min		Birthplace (State or reign PA
À		Usual Residence of Decedent 10a. State 10b. County		Idoo City	Town or Loca			1 - 1		10d. Inside City Limits
nd show any sce.	_	Maryland Cari	coll	Toc. City,	TOWN OF LOCE	illor)	Tane	eytown		1 X Yes 2 No
th the Maryland 23a or 28a-f show notified at 00cc.	Director	10e. Street and Number 28 Middle Street	et			10f. Zip Code	2178	37	10g. Citizen of What C	ountry?
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiest the matter all or items 23a or 23s-f she traumatic event, the Medical Examiner must be notified at socce	Funeral	_ 4_	arried 12. Was Dec Armed Fo 1 Yes orced If Yes, Give Yea	2 X No	lf'	as Decedent of H Yes, specify Cuba	ın, Mexican, Pu	(Specify Yes or lerto Rican, etc.)	White, etc	nerican Indian, Black, white
hours afte "natural" Examioe	d by	15. Decedent's Education (Spec	or Dates:		16a. Decede	nt's Usual Occupa	ation (Give kind		16b. Kind of Busines	ss/Industry
5-0036 led within 72 ho Hygiene. other thao "na	Completed	Elementary/Secondary (0-12)	College (1	-4 or 5+)	_	nost of working life Mechanic				obiles
1215-0036 d be filed within 7 lental Hygiene. arked other thao	Be	17. Father's Name (First, Middle, Harold W. Fa 19a. Informant's Name/Relations	air, Sr.		Louis		Dor	is Crumk		
MD 21; nd 2 should that and Mer aumatic eve	To	Jerry Fair,							iumber, City or Town, St /alley, PA	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within the perment of Health and Mental Hygene. Important: If item 27 is marked other the injury or other traumatic event, the Med		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other Sp.				sition (Name of co ther place) Cremato		Date 5/30/2012	20c. Location - City Winfie	
3altinermit. Departmining		21. Signature of Funeral Service	Licensee		22.	Name and Addres	s of Facility	Myers-Du	urboraw Fundaeytown, MD	eral Home
Physician		Justin R. Durb 23a. Part I. Enter the disease, or failure. List only one cause	complications that ca					<u>·</u>		Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a Chronic	Alocoho		with Cir	rhosis	of the 1	liver	Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a	consequence of)	:					
ansit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):						
ficate be executed sphysician and the burial - trans	dical	X UNPENDED	X AMENDED	21,per	DVR,23	a,27,per	me,g92	28 6-12-	12 sm	
ion of Vital Records, P.O. Box 68760, teading Physician: The law requires that the death certificate be sain. or: After this certificate has been signed by the attending physici the funeral director, page 2 should be detacled for use as the buri	Physician/Med		1 Live b 4 Pregn 9 Unkno	ant at time of deal	2	etal death 3 ther (Specify)			23d. Date of deliv Month	Day Year
P.O.	þ	Part II. Other significant conditi	ons contributing to	death but not res	sulting in the	unoerlying cause	given in Part I.		tobacco use contribute fes 2 No 3 P	to tne cause of oeath?
ecords, he law require ate has been si	Completed								opsy prior t formed? death	
tal Rection: The certificate ector, page	Be C	25. Was case referred to medical examiner?	Hospital:				of Death (Cho	eck only one)		
of Vige Physical Characteristics	P	1 ✓ Yes 2 No 27. Manner of Death	28a. Date	· <u> </u>	R/Outpatient 28b. Time of		Iry at Work?	rsing Home 5 28d. Describ	Residence 6 🗹 Otle e how injury occurred	ner: Scene
Division tal or Atteudin s after death al Director: A led in by the fu	Certification:		ing tigation	e of Injury - At hon	ne, farm, stre		Yes 2 No	28f. Location		Rural Route Number, City
Eile Gub.		4 Homicide deter	mined (Specify)	t of my knowledge	e, death occu	rred at the time, d	ate and place,	or Town,	, State) luse(s) and manner as si	ated.
To the Hos within 24 h To the Fun	Medical	one) 2 Medical Exam	miner: On the basis of and manner st	of examination and		tion, in my opinio	n, death occurr		te and place, and due to	the cause(s)
	Σ	29b. Signature and title of certifie		7	05	29c. Licen: O.C.			29d. Date signed (A	nonth, Day, Year)
		30 Name and address of person Russell Alexander MD		e of death (Item 2 ledical Exami		W. Baltimore	Street, Ba	Itimore, MD 2	1223	

12-03735 Jimmy Gamez

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 17548

		I- For State Registrar	,	Certifica	ate of Death			Reg. No.	, _ 0
Physicia	n/	1. Decedent's Name (First, Mi		<u> </u>			Date of De Month	Day Year	3. Time of Death
Medical Examir		Jimmy	VITAlino	Ga	MEZ	wn, or Location	May 15, :	2012 4c. County of Dea	1755 hrs
		4a. Facility Name (if not institu 634 Blossom Drive	ition, give street and number)		Rockvi		Of Death	Montgomery	
Funeral		5. Social Security Number	6. Sex 7. Age (In yrs. last birtl	nday) If Under	1 Year If Und	er 24Hrs. 8. Date of B	irth(MM/DD/YYYY) 9. B	irthplace (State or
Director		530497425	10M 20F 22		Yrs. Months	Days Hours	s Min. 5/7/	1990 Fore	country) Nevada
	t	Usual Residence of Decedent							
w any		10a. State 10b. Coun	·	Oc. City, Town					10d. Inside City Limits 1 Yes 2 No
rland -f sho	ğ		ntGomery	KOCK	10f. Zip (a da		10g. Citizen of What Co	
e Maryland or 28a-f show lied at once.	Director	10e. Street and Number	INBrook PKU	101 H				1) SA	unu y r
15-0036 filed within 72 hours after death with the Maryland I Hygiene. Is other than "natural", or items 23s or 28s-f sho i, the Medical Examiner must be notified at once.		13009 \w	12. Was Decedent Ev				gin? (Specify Yes or N	lo- 14. Race - Ame	erican Indian, Black,
eath w	Funeral		Married Armed Forces?	-No	If Yes, specify	Cuban, Mexicar	n, Puerto Rican, etc.)	White, etc.	,
ufter d	Į F	3 Widowed 4	Divorced If Yes, Give Year or Dates:] 140	1 Yes 2	No specify	Mexican	Specify:	spanic
natur:			specify only highest grade comple		Decedent's Usual D during most of work			16b. Kind of Business	s/Industry
36 In 72 l	Completed	Elementary/Secondary (0-1	(1-4 or 5+)) []-	lectric	ian		Electric	Company
5-00.	E	17. Father's Namo (First, Mide	dla, Last)		1201110		r's Name (First, Middle		
21215-0036 uld be filed within 72 hours Mental Hygiene. marked other than "nature event, the Medical Exam	Be	Enrique	2 GAME	Z		The same of	sey al	ONZO	
	힏	19a. Informant's Name/Relation			. Mailing Address	(Street and Nur	mber or Rural Route Nu	ımber, City or Town, Sta	te, Zip Code)
nore, MD 2 ages 1 and 2 shou to of Health and I to If item 27 is r other traumatic		LUCRY Gar 20a. Method of Disposition	mez /wother	20h Place	3009 of Disposition (Name		15/00/C P1	KWOY #206	20851
ore, Nes 1 and of Health If item			tion 3 Removal from State	cremate	ory or other place)	_	5/24/12		
		4 Donation 5 Other 21. Signature of Funecal Serv		Gate	OF I Voo				ring, MD
Balti permit. Departu Imports injury		21. Signature of Funetal Serv	Nemus		BKI	Joney	toneral W	DWD MOZEH	DC" SOOS
Physician	d	28a. Part Enter the disease	, or complications that caused the	e death. Do no	at enter the mode of	dying, such as			Approximate Interval Between Onset and
/Medical	- 1	failure. List only one cau Immediate Cause (Final disea	0	otgun W	ound Of F	lead			Death
Examiner	-	or condition resulting in death							
	<u>_</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ	uence of):					
	Ē	cause. Enter Underlying Cau (Disease or injury that initiate	d c.						
ed nsit	Examiner	events resulting in death) La	st Due to (or as a consequ	uence of):					
executed an and al - transit		X UNPENDED	d	27,28a-	f.per me.	g929 7-	·5-12 sm	-	
760, icate be exe physician a	Medical	IF FEMALE:	23c. If yes, outcome					23d. Date of delive	ery
687 ertifica ding p		23b. Was decedent pregnant i past 12 months?	n the 1 Live birth 4 Pregnant at tin	no of death			ic pregnancy	Month	Day Year
Box 687 e death certific the attending	Physician	1 Yes 2 No 9	Unknown 9 Unknown	me of death	Other (Special	ý)			
O. B nat the de		Part II. Other significant cor	nditions contributing to death b	out not resulting	g in the underlying	ause given in P	art I. 23e. Did	tobacco use contribute	to the cause of death?
res tha	d b						1 TY	es 2 🗸 No 3 🗌 Pr	obably 4 Unknown
ords w requires been as been a	Completed							opsy prior to	autopsy findings available ocompletion of cause of
eco he law ate has	E I						peri 1 ✓ Yes	formed? death?	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the start cleath. *I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detailed.	Be C	25. Was case referred to med examiner?			26		(Check only one)		
Vit.	2	1 ✓ Yes 2 No	Hospital: 1 Inpatient		utpatient 3 DC		<u> </u>	Residence 6 🗸 Oth	er: Scene
n of ding Ph		27. Manner of Death 1 Natural 5 P	28a. Date of Injury (Month, Day, Year	28b.	Time of Injury 28	c. Injury at Wor		e how injury occurred t shot self	=
Sior Attend r death ector: by the	cati	2 Accident Ir	nvestigation 28e Place of Injur		05:00 pm				Rural Route Number, City
Divisal prital or At ours after deral Direct filled in by	Certification:		could not be	ınd:Res		,	or Town,	State) 634 Blos 11e MD.	som Dr.
Hospit 14 hour Funer cly fill			g Physician: To the best of my k			me, date and p			ated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical		Examiner: On the basis of examinand manner stated.						
H 3 H 5	X	29b. Signature and title of cer	tifier		29c.	License number	r	29d. Date signed (A	fonth, Day, Year)
		all L	X	/ /	1	O.C.M.E.		May 16, 2012	
			son who completed cause of dea MD. Assistant Medical	ath (Item 23a)	900 W Ball	more Stroot	Raltimore MD 2	1223	•
	250	Russell Alexander I 31. Date filed (Month, Day, Ye			= OU VV. Dalli		- Daillimore, IVID 2	1220	
Regist	ate rar	11IN 0 4 2	012		Med				
DHMH 17 Rev 1/2	001	0011-0	- John -	OR	IGINAL			OCME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death RegistrarAMEND#20boerFH.5/21/12; EMW.McCo 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Month May Pear1 Golacinski 13, 7:20 am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9828 Cherry Tree Lane Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) Director 215-52-5080 1 M 2 T F 85 19, 1926 Usual Residence of Dec Morocco 28a-f show 10b. Count or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9828 Cherry Tree Lane 20901 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black White, etc. <u>م</u> 1 Never Married 2 Married Maryland 21215-0036 Specify:White 1 Yes 2 No Specify: If Yes Give 3XXWidowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Maurice Abecassis Messodi Abecassis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniellle Golacinski/Daughter 10030 Dallas Avenue, Silver Spring, MD 20901 3altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Dateunk 20c. Location - City or Town, State 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National 5-23-2012 Arlington, VA Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, 21. Signature of Funeral Service Licensee MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alzheimer's Disease Pnysiciani disease or condition Medical resulting in death) Due to (or as a consequence of) Éxaminer Congestive Heart Failure 10 yrs Sequentially list conditions, it my earling to miniculate cause. Enter Underlying Cause (Disease or injury Due to jor as a consumence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and empletely filled in by the funeral director, page 2 should be detached for use as the burial these. Exami ed by the attending physician and detached for use as the buria-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XXNo 5 Other (specify) Month Day Year Pregnant at time of death 1 ☐ Yes 2½ 9 ☐ Unknown 9 Unknown n signed by ti. 1 be de⁺ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Coronary Artery Disease, Atrial Fibrillation Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an performed Yes 2 X N **Division of Vital** 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 🔀 Residence 6 Chter (Specify) Hospital 1 ☐ Yes 2 ☐ No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

address of person who

MD

Janet Jones

MAY 17

31. Date filed/(Month, Day, Year)

pleted cause of death (Item 23a) (Type, Print)

. Registrar's Sign

9-111 ory

(WRNMMC)

8901 Wisconsin Avenue, Bethesda, MD 20899

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Donald L. Hovatter Sr. May 17, 2012 07:29 AM M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 19329 Lower Consol Road Allegany Frostburg Social Security Number If Under 1 Year If Under 24 Hrs Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign **X** M 2 □ F Days 214-34-1661 79 (Month, Day, Year) 1933 Director Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Allegany Frostburg 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 19329 Lower Consol Road 10g. Citizen of What Country? Funeral 21532-U.S.A 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian 1 Never Married 2 Married Black, White, etc. Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White "natural", 3 - Widowed 4 - Divorced Year or Dates. Koreo other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry should be filed within and Mental Hygiene. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Small Engine Repair Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Alston Gordon Elizabeth Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Erma Hovatter Wife 19329 Lower Consol Rd Maryland 21532-Frostburg 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State Frostburg Memorial Park May 19, 2012 Frostburg Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility ohu Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Carcinoma disease or condition resulting in death) month Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that in the cause that is the cause the cause that is the cause the Due to (or as a consequence of): Exami that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? this certificate 1 ☐ Yes 2 ☐ No Yes Division of Vital To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: မ 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 No within 24 hours after death

To the Funeral Director: A
completed filled in by the f Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11:11AC HUMMER MAY"14,2012 Physician/ ROBERT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Deatl Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min (Month, Day, Year) 196-14-3217 **Director** 1**X** M 2 □ F 92 Yrs. 07 1919 St. Thomas, PA 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director PA Franklin Greencastle 1 Yes 2 X No 10f. Zip Code ō 10e. Street and Numbe 10g. Citizen of What Country? **23**a Funeral 17225 US 3866 Williamson Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 6 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: white "natural", 3 X Widowed 4 □ Divorced Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) crane mfg. laborer marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental F 7 is marked o ည Bertha Sites Soloman D. Hummer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 and 2 s of Health item 27 3866 Williamson Rd. Greencastle, PA Robert L. Hummer, Sr. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Brown's Mill Cemetery May 18,2012 Greencastle, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Miller-Bowersox Funeral Home re of Funeral Service Licensee 21. Signa ▶ 521 S. Washington St. Greencastle, PA Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final PROBABLE MYOCARDIAL INFARCT. - Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury Due to (or as a consequence of) Exam certificate be executed -tran and that initiated events Due to (or as a consequence of): resulting in death) Last burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the SB IF FFMALE: signed by the attending be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death
Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 A No page 2 certificate has To the Hospital or Attenuing Physician: Within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 降 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 20c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 5/15 2012 DØØ 35267 MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Manuel

31. Date filed (Month Pay

Casiano MD

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FREDERICK, MD

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egistrar's Signatu

21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, AMEND 7-9 PER FH G928 6/27/12 TRT State of Maryland / Department of Health and Mental Hygiene 20 | 2

State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ М 2012 William H. Hornbaker Mav 2:37 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington 1032 Brinker Drive Hagerstown If Under 1 Year | If Under 24 Hrs. 8, Date of Birth 9, Birthplace (State or Foreign 7. Age (In vrs. last birthday) Social Security Number Funeral 1 X M 2 □ F Months Davs Hours Min. (Month, Day MAY 23 Country) 65 Director 168-36-9202 1946 PA 28a-f show 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits must be notified at Director Washing ton MDHagerstown 1 X Yes 2 No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 21740 Funeral Drive Brinker USA 1032 items death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. "natural", or **会** 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify White Specify: Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) School Custodian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ Horn baker Blaine LUCY 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 21740 1032 Brinker Drive Hagerstown, m D Hornbaker Shirley 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Mercersburg, PA May 25, 2012 Grove Cometery 22. Name and Address of acility Lininger-Fries Funeral Home Mercersburg 17236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani -Ung M (month disease or condition Medical resulting in death) Due to (or as a onsequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) death certificate be executed Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last physician a s the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 attending philosophia at the second s IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death been signed by the should be detached 1 L Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy perform rmed? 2 █ No or Attending Physician: The this certificate 2 No 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 🛣 No Hospital Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 X Residence 6 Other (Specify) To the Hospital or Attending Physwithin 24 hours after death.

To the Funeral Director. After this completed filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending 1 X Natural injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 0072-463 May 22, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mouhamad Bazzi, MD, 1130 Opal Court, Hagerstown, Maryland 21740 31. Date filed (Month, Da State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Maryland /	Department of He	ealth and Menta	l Hygiene

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Registr		MAT	LO DI		estimate.	A. Ma	be the same							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 22^{Day} Physician/ Mav 20°1°2 9:05 AM Patsy Lucille Hockenberry Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington County Hagerstown 2007 Starlight Lane 1D If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Min Months Hours 213-40-3336 1 □ M 2 🗓 F 72 Director April 4,1940 Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location with the Maryland must be notified at Director 1 Tes 2 X No Maryland Washington County Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a Funeral U.S.A. 21740 2007 Starlight Lane 1D Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death items 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 6 1 X Never Married 2 Married Completed by permit. Page 1 and 2 should be filed within 72 hours after. Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Corrugated Box Mfg. Administrative Assistant 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Nona Roberts Roy McClellan Hockenberry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 218 Boone Hollow Dr. Wentzville, MO 63385 Andrew Hockenberry-son 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4

▼ Donation 5

Other (Specify) Baltimore, MD Anatomv Board 22. Name and Address of Facility Douglas A. Fiery Funeral Home Signature of Funeral Service Lige 1331 Eastern Blvd. North Hagerstown, MD 21742 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as candiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Fhysician/ Cardo memora disease or condition Medical resulting in death) **Examiner** sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine mply sems the burial-transit Cause (Disease or injury that initiated events and resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Pregnant at time of death 5 Other (specify) signed by the at be detached for 1 Yes 2 signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No certificate 25. Was case referred to me ca 26. Place of Death (Check only one) Certificate: To Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Hesidence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 5 Pending s after death. Accident Investigation filled in by the Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check d title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Zo fav Mauk MD 20 3 i)

State Registrar 31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day PEGGY ANN IRONS 16:50 A.M Medical 05 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 11502 Bierman Drive, S.E. Allegany Cumber1and Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X I Hours 08/17/1931 213-24-5302 80 Director Maryland Usual Residence of Decedent 28a-f shov 10a. State "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 🗆 Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11502 Bierman Drive, S.E. 21502 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death \
Department of Health and Mental Hygiene.
Important I fitem 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alfred Charles O'Baker Dorothy May Dunn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James N. Irons/Husband 11502 Bierman Drive, S.E., Cumberland, MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery crematory or other place)
Davis Meml. Cemetery 05/12/2012 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licens Name and Address of Facility Upchurch Funeral 202 Greene St., Cumberland, MD COX 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) ceu years Medical Examiner Sequentially list conditions cause. Enter Underlying Exami The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and tran Due to (or as a consequence of) nding physician a use as the burial-1 Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? for Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of 24a, Was an page 2 autopsy Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 1 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifia 29c. License number 29d. Date signed (Month, Day, Year) latel D46346 www 1912012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

MAS

Huma Shakil, M.D. - 625 Kent Avenue, Cumberland, MD 32. Registrar's Signature

MAY 1 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2012 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month INGLE CLYDE 1643 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Hours 217-70-5851 1 M 2 F 54 Jan. 12, 1958 Kentucky Usual Residence of Decede 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24605 Marlboro Drive 20872 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 Tes 2 No Specify Specify. 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Construction Superintendent Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Deloris C. Wynn Jacob W. Ingle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 24605 Marlboro Drive, Damascus, Maryland 20872 Mrs. Joyce I. Ingle, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Kemptown Providence 05/18/2012 4 Donation 5 Other (Specify) Kemptown, Maryland al Servige 21. Signature of FV 22. Name and Address of Facilit Molesworth-Williams, P.A., 26401 Ridge Road, Damascus Funeral Home Marvland 20872 ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock or heart failure. List only one cause on each line. Immediate Cause (Final Infarction Acute Myocardial disease or condition resulting in death) mante Due to (or as a consequence of): Coronary Artery nours Discase Sequentially list conditions, Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Pregnant at time of death 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician/ Medical Examiner Examine

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Medical

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Director

Funeral

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Department of Health a Important: If item 27 is any injury or other tra

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the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran the as for use ned by the a e detached i page 2 s certificate has director. filled in by the funeral

Division of Vital Records, P.O. Box 68760

Physician/Medical

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2 Accident

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Investigation 6 Could not be

determined

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1 Inpatient 2 ER/Outpatient 3 IDOA 28b. Time of 28a. Date of injury (Month, Day, Year)

injury

28c. Injury at work? 1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

62553

Drive,

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Maintenance: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. erkifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year)

pockville, manland 20850

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Registrar

atsy MaNeil, MD 31. Date filed (Month, Day, Year)

30. Name and address of person who completed

990) Medical Center 32. Registrar's Signature

MD

cause of death (Item 23a) (Type, Print)

barres

24 hours a

completely.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Gene Johnson, Jr. State of Maryland / Department of Health and Mental Hygiene 2012 17557 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Day May 17, 2012 **Medical Examiner** 0210 hrs Gene Howard Johnson, Jr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** Months Days Hours Director 1 X M 2 F 24 10/06/1987 Country) NY 065-76-7696 Usual Residence of Decedent 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits or 28a-f show 1 X Yes 2 No Washington Hagerstown Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 1842 Londontowne Circle 21740 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married White etc. 2 X No Yes 3 Widowed 4 Divorced if Yes, Give Year 1 Yes 2 X No specify: Black Specify: ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 th Student Education 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) Be Gene Howard Johnson, Sr. Judy Ann White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy A. Johnson / Mother 1842 Londontowne Circle, Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State ltimore, 1 X Burial 2 Cremation 3 Removal from State crematory or other place) portant: 05/25/2012 Rose Hill Cemetery Hagerstown, MD 4 Donation 5 Other Specify 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licensee 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death aAcute and Subacute Myocardial Infarctions Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) bAcute and Subacute Coronary Artery Thromboses Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause cAtherosclerotic cardiovascular Disease (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and - transit Physician/Medical AMENDED 23a-c, 27, per me, $g_{928} = 6-5-12 \text{ sm}$ attending physician for use as the burial -X UNPENDED . Box 68760, he death certificate be e IF FFMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the this certificate has been signed by all director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed' ✓ Yes 2 No 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ✔ ER/Outpatient 3 ☐ DOA Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 2 No ဥ After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 1 Yes 2 No death. 5 Pending To the Funeral Director: the 2 ___ Accident Investigation ρ 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 17, 2012 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Pay, 32. Registrar's Signature State

DHMH 17 Rev 1/2001 OCME 2006

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5 Physician/ Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Tate Hospice House Linthicum Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 0ct.6, 1967 Days Hours Director 216-78-1053 1 【XM 2 □ F 44 Yrs 28a-f show of Health and Mental Hyglene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits Temple Hills MD Prince Georges 1 🗆 Yes 2 🖺 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4535 Deer Park Road 20748 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 X Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Divorced Specify: Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) Chemistry Emergency Service Spec. Be 17. Father's Name (First, Middle, Last) 18, Mother's Name *(First, Middle, Maiden Surname)* Elizabeth Holland Mervin Jones, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3009 Ponds Wood Rd. Huntingtown, MD Velma Scayles/sister it of Health a Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If i any injury or or 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro. Crematory 5/17/2012 4 Donation 5 Other (Specify) Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell 1451 Dares Beach Rd. Funeral Home, P.A. Prince Fred.,MD20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Deticina Physician/ disease or condition resulting in death) Medical Examiner Due to or as a consequence of): Lavs Sequentially list conditions Examine if any, reading to immediate cause. Enter Underlying Cause (Disease or injury as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical of or Attending Physicians. The law requires that the death certificate be after death.

Director: After this certificate has been signed by the attending physici. P.O. Box 68760 for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Year ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by signe 1 be d 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 2 No Yes 2 No 1 Yes Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☐ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) MUSPIC 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of HOUSE 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours To the Funeral I Medical 1 Kcrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number 16/12 445 Defense Hwy Annapolis, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JRW 10 RSH 31. Date filed (Month, Day, Year) 32. Registra s Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 13, 2012 ay 12:23 р м Halston Jones Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death 45955 Fox Chase Drive Apt. 819 Great Mills Saint Marys If Under 1 Year | If Under 24 Hrs. Age (In vrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Days Hours December 1, 1941 Country) Director 214-44-0302 Usual Residence of Decedent 28a-f shov 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Saint Marys **Great Mills** 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 45955 Fox Chase Drive Apt. 819 20634 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates Black if Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Licensed Boiler Engineer Maintenance Department of Health and Mental Hygie Important; If item 27 is marked other 1 any injury or other traumatic. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျပ John Jones Virginia Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4436 Flintstone Road Alexandria, VA 22306 Melvin Jones - nephew 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State Metropolitan Crematory May 16, 2012 | Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Sewell Funeral Home, P.A. 21. Signature of Funeral Service Ligorises 22. Name and Address of Facility 1451 Dares Beach Rd. Prince Frederick, MD 20678 Whon 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final + Pnysician/ disease or condition resulting in death) Medical Due or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Liter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) transit and Due to (or as a consequence of) resulting in death) Last physician as the burial-1 Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year been signed by the should be detached 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Grand maleplepsy Alcon Division of Vital Records, 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Diabeles 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed certificate Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) BUMD Gideli DS 62123 05/16/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ee Noteh Abad. Holywood MD 20636 snahid

State Registrar 32. Registra's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Charlotte Kenton May 2012 2:20 am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 4601 North Park Avenue. Chevy Chase Montaomeru Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) **Funeral** Months Hours 1 □ M 2 🂢 F Director 120-16-0774 86 08/12/1925 New York Usual Residence of Decedent 28a-f show ms 23a or 28a-f sho must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Maryland Chevy Chase Montgomery 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4601 North Park Avenue, #403 20815 U.S.A. or items 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner 1 ☐ Yes 2 No If Yes, Give Armed Force Black, White, etc. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify "natural". 3 Widowed 4 Divorced Vear or Dates Caucasian other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than National Institutes Elementary/Secondary (0-12) College (1-4 or 5+) **5+** Medical Librarian of Health Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental h 2 Samuel Kofsky Rachel Cohen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s if Health item 27 Bruce D. Patner - Attorney 5530 Wisconsin Ave., #112. Chevy Chase, MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 and Department of Hamportant: If ite any injury or of 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 05/21/2012 Brentwood, Maryland 21. Sign dure of Fun on Strvice Lio nsee 22. Name and Address of Facility Simple Tribute Funeral & Cremation Ctr. M00209 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death & Months Immediate Cause (Final disease or condition Physician Acute Myelogenous Leukemia Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and I-transit The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 X No Day Month Year been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page perform Yes 2 N certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific apmpletely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 💢 No Other: ျပ 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 X Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 06-2011

State

Fred Barr,

5454 Wisconsin Avenue,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

MAY 1 7 2012

D22775

#1300, Chevy Chase, Maryland 20815

May 11, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First_Middle_Last) 2 Date of Death Physician/ Day 2012 Virginia May LEWIS 18, 11:20 AM May Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1003 Georgia Avenue Hagerstown Washington Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Sept. 17,1925 1 M 2 X F 220-18-1141 86 **Director** Maryland Usual Residence of Decedent shov 10a. State ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Maryland Washington Hagerstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1003 Georgia Avenue 21740 U.S.A. ural", or items 2 Examiner mus Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 Tes 2 X No Specify: "natural", Specify Completed 3 Nidowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) the homemaker her own home other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked o မ William W. Crabtree Margaret Gillam and i 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 is Doris Crabtree -sister-in-law 12319 Delwood Avenue, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State May 22012 4 Donation 5 Other (Specify) Rose Hill Cemetery Hagerstown, Maryland Signature of Funeral Service 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Par/1. Enter the disease, or complication shock, or heart failure. List only one de ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician. estive Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death the detached 9 Unknown 9 Unknown signed by the si Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 Yes 2 No Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Tes 2 No မ 1 Inpatient 2 Inpatient 3 Inpa 4 Nursing Home 5 Residence 6 Other (Specify After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1. Natural 5 Pending nours after death. death. 1 Yes 2 No Accident 2 ☐ Accide... 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify, Funeral 24 hours Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie D0066930 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21740 CNISYL a 9 CRSTOWN

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05 20 Year 750 AM 4a. Facility Name of not institution, give street and number) Medical 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Fahrney Keedy Home Boonsboro Washington 4 Willag If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last bii 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 217-18-8264 Director 1 XM 2 □ F 91 Dec.9, 1920 Virginia Usual Residence of Deced or 28a-f show e notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Washington Boonsboro 5 10g. Citizen of What Country? be 23a Funeral must 8507 Mapleville Road 21713 USA "natural", or item ledical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced White Year or Dates than "natura the Medical E Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ulth and Mental Hygiene. 27 is marked other than r traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 8 Lawn Equipment Sales Parts Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F. 7 is marked ** ၉ Charles Edward Litten Elsie Davenport Newlin Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Blanche V. Litten - Wife 8507 Mapleville Rd. Boonsboro, Maryland 21713 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Dopation 5 Other (Specif May 24,2012 Tilghmanton, Maryland Cemetery ure of Fun 22. Name and Address of Facility Osborne Funeral Home, P.A. ral Service 425 S. Conococheague St. Williamsport, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death .Physician re Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or injury 34 use as the burial-tran that initiated events resulting in death) Last Physician/Medical death certificate be IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death been signed by the a should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 1 Tes Yes of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined within 24 hours a To the Funeral D Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I Exertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Manahan 11260 pal Ct. Hagerstown, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 15, Day 2012 ar Physician/ THELMA Z. LOURIE MAYonth 7:30A. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death
Montgomery Rockville Casev House 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 578-24-1201 Months Days Hours March 10, 1925 Director 1 □ M 2X F 87 Marvland Usual Residence of Decedent or 28a-f shov Page 1 and 2 st ould be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Fart: If item 27 is marked other than "natural", or items 23a or 28a-f shoilury or other trainmatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Montgomery Silver Spring 1 Yes 2 XNo 10f. Zip Code 10g. Citizen of What Country? Funeral 3142 Gracefiedl Road, #MG505 20904 United States 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes Give 3 X Widowed 4 □ Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Louis Zeskind Ida M. Denaburg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 9007 Fairview Road Silver Spring, Maryland 20910 John M. Lourie -son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. Date cemetery, crematory or other place)
King David Mem. Gardens 1 X Burial 2 Cremation 3 Removal from State 5/20/2012 Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licepa Bonald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Leukemia Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir ate has been signed by the attending physician and page 2 should be detached for use as the burlahtransit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 D Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown 5 Other (specify) Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The law within 24 buturs after death.
To the Funeral Director: After this certificate has gompletely filled in by the funeral director, page 2. autopsy ☐ Yes 2 X No 1 ☐ Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 💢 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 10 143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Debrah Miller, CRNP 6001 Muncaster Mill Road Rockville, Maryland 20855

State Registrar 31. Date filed (Month, Day, Year)

2012

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Maryland / Department of Health and Mental Hygiene		2012	17561
Certificate of Death	-	2012	11004

		1- For State Registrar		Certi	ficate of	Death			Reg	g. No.	201	2 1130
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MD 21215-0036 2 should be filed within 7 h and Mental Hygiene. 27 is marked other than martic event, the <u>Medical</u>	ဦ	19a. Informant's Name/Relation				Address (Stre						
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Sox 687 leath certifi e attending for use as t	Sai	past 12 months?	1 Live birth 4 Pregnant at	time of death	_ =	Il death 3 er (Specify)	Ectopic p	леднансу		Mon	iii) D	ay Year
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	ł	30. Name and address of perso	on who completed cause of de	eath (Item 23	la)							
		Pamela E. Southall, I				W. Baltimor	re Street, I	Baltimor	e, MD 212	223		
St Regist	ate	31. Date filed (Month, Day, Year MAY 30	012 Registrar	s Signature	parto	2.						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 17565 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Fileen Month 2:23 AM Medical 4a. Facility Name (i) not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death University of Manyland Medical Britimore Center . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 216-60-5342 Hours 60 **Director** 1 M 2X F 03/21/1952 PA Usual Residence of Decedent show 10a. State the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f MD Harford Havre de Grace 1 X Yes 2 No 10e Street and Number ō 10f. Zip Code ms 23a or must be r 10g, Citizen of What Country? Funeral 100 Revolution Street United States 21078 Apt. 512 items death 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Force Black, White, etc. ō þ 1 Never Married 2 Married ☐ Yes 2 💢 No Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 Yes 2XXNo Specify: Specify:White "natural", Completed 3 Widowed 4XXDivorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Welding Elementary/Secondary (0-12) College (1-4 or 5+) 1 Welder Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o မှ Louise Trivalpiece traumatic Harry Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a Jeanette Hardy/Daughter 97 Love Run Rd. Colora, MD 21917 other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or conce. ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 05/23/201 Tucson, AZ 2 LifeLegacy Foundation 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility D'Alessandro Funeral 4522 Bitler Street Pittsburgh, PA 15201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final liver failure Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami burial-tran and resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical certificate be P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy ξō Pregnant at time of death Month Dav 5 Other (specify) Year signed by the a 1 Yes 2 a Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has perform 1 Yes 2 No pletely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 1 \square Yes မ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural 5 Pending (Month, Day, Year) work 2 ☐ Accident 3 ☐ Suicide М 1 ☐ Yes 2 ☐ No Investigation Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 241 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 Certifying Nurse Practitioner: To the best of my knowledge. occurred at the time, date and place, and due to the cause(s) and mainter as stated 29b, Signature and title of certifie 1750601407

DHMH 17 Rev 06-2011

Registrar

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31. Date filed (Mor

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Autumn Assisted Living 5. Social Security Number 6. Sex 11 May 17, 2012 10:33 P 4b. City, Town, or Location of Death Hagerstown If Under 1 Vear If Under 24 Hrs. Months Days Hours Min. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10c. City, Town or Location May 17, 2012 10:33 P 4c. County of Death Washington County If Under 1 Vear If Under 24 Hrs. Months Days Hours Min. Jan. 14, 1948 West Virginia 10d. Inside City Limits		State Registrar 1 Decedent's Name (First Middle Least)		Ce	ertificate of	Death	Reg.	No. ZUIC	2 1756
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19a. Normant's Nama-Pelationship (Type, Print) 16b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16202 Lappens Road, Williamsport, MD 21,795 20a. Method of Disposition 1 21 Microration 5 24 Mere autopsy for flowing state 22 Normal and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22a. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22a. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown, Maryland 21. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown, Maryland 21. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown, Maryland 21. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown, Maryland 21. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown, Maryland 22a. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown, Maryland 21. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown, Maryland 22a. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown, Maryland 22a. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown, Maryland 22a. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown, Maryland 22a. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown, Maryland 23a. Date of July Year 23a. Date of July Year 23a. Date of July Year 23b. Date of	1								
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22. Name and Address of Facility Doug Las A. Fierry Funeral Home 1331 Fastern Blvd. N., Hagerstown, Maryland 217. 23a Part I. Enter the Jesses, or complications that caused the July 23a. Part I. Enter the July 23a. Part II. Other significant conditions, inhalated events a consequence of): 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23a. Date of delivery Month Day Year Individual 25a. Place of Death (July 25a. Date of July			Removal from State	cernetery, cre	ernatory or other plac	ce)			
1331 Eastern Blvd. N. Hagerstown, Maryland 21 23a Part. Enter beases, or complications that caused the set. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate such as consequence on each line. Approximate cause (final immediate Cause (final resulting in death) Due to (or as a consequence of):			ee	2	22. Name and Addre	ess of Facility Doug	7, 2014 SI	iery Func	, raryrand
Approximate interval cause (final disease or conditions. Interval cause of the conditions of the condi		Dundant	Fi	1	331 Easte	rn Blvd. I	V Hager	stown. Ma	eral nome ervland 211
Second Control Contr	1	Shock, or hear a llure. List only or Immediate Cause (Final disease or condition	ne cause on each lin	th the th. Do not er	nter the mode of dyi	ng, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
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1 Yes 2 No 3 Probably 4 Jeffknown		Sequentially list conditions, it may be a cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence of):				i.	
1 Yes 2 No 3 Probably 4 Improved 24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 Improved 25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Other: 4 Nursing Home 5		Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	,				10.0	
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25. Was case referred to medical examiner? 1 Yes 2 Jeb 1 Impatient 2 ER/Outpatient 3 DCA 26. Place of Death (Check only one) 27. Manner of Death 1 Matural 2 Accident 3 DCA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describ	by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a d	a consequence of): of pregnancy 2 ☐ Fetal death 3 t time of death 5 ut not resulting in the	Other (specify) _	ven in Part I.		Month co use contribute to	Day Year the cause of death?
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Annabelle Mellott 0627 M 012 Medical a.Facility Name (if not institution, give street and number) Meritus Medical Center . City, Town, or Location of Death Hagerstown **Examiner** Washington If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 220-18-0666 Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 89 Days Hours Month, Day Year 922 **Director** 1 🗆 M 2 💢 F MD Usual Residence of Decedent or 28a-f show 10a. State 10b. Count 10c. City, Town or Location Boonsboro event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Washington Yes 2 No 10e. Street and Number 141 S. Main Street 10f. Zip Code 21713 10g. Citizen of What Country?
U.S.A. Funeral 23a and 2 should be filed within 72 hours after death. Health and Mental Hygiene. tem 27 is marked other than "natural", or items 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc white þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) aircraft Elementary/Secondary (0-12) 8th grade assembler Be 18. Mother's Name (First, Middle, Maiden Surname)
Viola Willett Myers Father's Name (First, Middle, Last)
Mayette Emerson Smith 19a. Informant's Name/Relationship (*Type, Print*) Joann Martz daughter 19b, Mailing Address (Street and Number or Rural Route Number City or Town, State, Zig Code) 11731 Cedar Ridge Rd. Williamsport, MD 21795 Department of Healt Important: If item 2 any injury or other once. or other 20a. Method of Disposition 20b. Place of Disposition (Name of 5-23ª= 20c. Location - City or Town, State cemetery, crematory or other place)
Cedar Lawn Cem. 1X Burial 2 Cremation 3 Removal from State Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of Funeral Service Licenses ²² Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc .O.BOX 310 Clear Spring. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fattore. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Hours Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of)s Cause (Disease or injury that initiated events resulting in death) Last use as the burial-trar Due to (or as a eor attending physician Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physicial Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? Month Day Year the sate has been signed by the a page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 2 No Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the within 2 To the F only one) 3 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20311 lappans Rd Boonsboro MD 21713 31. Date filed (Mor State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 05 2012 Harry Raymond Monninger Jr. 12:30 р Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Washington Williamsport Homewood of Williamsport Social Security Number Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country Hagerstown 1 X M 2 T F Hours 04/14/1927 Director 215-20-7635 85 Usual Residence of Decedent shov 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 28a-f Hagerstown 1X Yes 2 No Maryland Washington ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral U.S.A 21740 17320 Cloverleaf Road items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Completed by "natural", or 1 Never Married 2 Narried 1 X Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other tran "ne any injury or other traumatic event at a once. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Publishing Mail Room Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry Monninger Sr. Edna M. Daley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores Monninger / Wife Cloverleaf Rd Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🗆 Burial 2 🕱 Cremation 3 🗆 Removal from State 05/25/2012 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory Smithsburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel Pennsylvania Ave Hagerstown, Maryland 21742 23a. Part 1. Enter the disease, or complications or beart failure. List only one as cardiac or respiratory arrest shock, or heart failure. List only one Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events the burial-trai Due to (or as a consequence of) resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Pregnant at time of death 5 Other (specify) Year ed by the a detached f 2 No g Unknown g Unknown Part LOther significant nditions contributing to dea out not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by be 1 Yes 2 XNo 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 director, To Be as case referred to medical 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral is 28a. Date of injury (Month, Day, Year) 27. Mannier of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident 2 No Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated pertifying (turns Fractionar). In the cause(s) and manner stated cause(s) and manner stated of the cause(s) a (Check 101 29d. Date signed Month, Day, Year) 201 TW-1 7

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Twila Jane McFadden Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Medical Center Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth oct. 9, 1933 West^{ry}Virginia **Director** 78 235-48-3976 1 □ M 2**X** F Yrs Usual Residence of Decedent 28a-f show and Merital Hygiene. Is marked other than "natural", or items 23a or 28a-f shor raumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Williamsport 1 Yes 2X No Maryland Washington 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 16409 Spielman Rd. 21795 USA death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examin one. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes Give 3 🛱 Widowed 4 □ Divorced Specify: Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Bookkeeper Bread Distribution & Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Theodore Holton Phillips Virginia Winifred 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 17720 Bluebell Drive Hagerstown, Maryland 21740 Cynthia A. Moir - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Hagerstown Crematory May 22,2012 Hagerstown, Maryland 21. Si Jane of Ameral Service Lice of 22. Name and Address of Facility Osborne Funeral Home, P.A. 425 S. Conococheague St.Williamsport, MD 21795 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition eu weinig Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events and use as the burial-tra Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year Pregnant at time of death should be detached the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has funeral director, page 2 autopsy certificate Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director, After this completely filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner_of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AND HAGERSTOWN. MM 21742 12821 HBDYL AHERD MO-

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Da

State of Maryland / Department of Health and Mental Hygiene

			State Registrar		Cer	tificate of i	Death		Reg. No.		
	Physicia	n/	Decedent's Name (First, Middle, Last)					2. Date of De Month	-	3.4	Time of Death
	Medic		Richard		colm				15 0	2010	1943 M
	Examin	er	4a. Facility Name (if not institution, give street	and number)			or Location of Death	١		y of Death .leg.	
with the	Funeval		5. Social Security Number 1 6. Sex	7. Age (In yrs. la	st hirthday)	Cumber of Under 1 Year	erland Tif Under 24 Hrs.	8. Date of Bir			(State or Foreign
	Funeral Director		213-24-7370 IX			Months Days	Hours Min.	(Month, Da	iy, Year)	Country)	(State of Foreign
	3		Usual Residence of Decedent					4-4-	-1929	WV	
	/land f sho ed at	to	10a. State 10b. County	10c. City	, Town or Loc	ation				- 1	nside City Limits
	Mary 28a- lotifie	Director	WV Mineral	Pi	edmon					1	X Yes 2 □ No
	th the		10e. Street and Number 293 W. Fairview	S+		10f. Zip Code 2675	50		-	What Country?	
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03	rs afte	ed k	O DAG danced A D Diverse I	☐ Yes 2 ☐ No Yes, Give ear or Dates. 51 —	54 1	☐ Yes 2X No	Specify:		Specify	white	
5-0	2 hou "natu edical	Completed by	15. Decedent's Education (Specify only highest grade control		16a. Deced	ent's Usual Occup	pation during most of wor	kina	16b. Kind of E	Business/Industr	у
Maryland 21215-0036	than 7	mo;	Elementary/Secondary (0-12) C	ollege (1-4 or 5+)	life. DC	NOT use retired))	9	Modes	72.00 E	ine Pap
Ω Β	Hygie Hygie other	Be C	12 17. Father's Name (First, Middle, Last)		Матп	L. Supe	18. Mother's Nar	ne (Eirst Middle			THE Pape
an	be file ental ked c	힏	Leonard L. Malo	olm					ington		
ary	nd Mi		19a. Informant's Name/Relationship (Type, Pri	int)	19b. Mailin	a Address (Street	and Number or Ru	ral Route Numbe	er. City or Town.	State. Zip Codel	
Σ	and 2 st Health a tem 27 is ther tra		Etta D. Malcolm	wife	293	W. Fair	rview St	. Pied	lmont,	WV. 26	750
ore,	of He of He fitem rothe		20a. Method of Disposition X□ Burial 2 □ Cremation 3 □ Remo	20b. P	lace of Dispos	sition (Name of	ce)	Date		- City or Town,	
<u>Ĕ</u>	Page ment tant: l		4 Donation 5 Other (Specify)	Varifolii State F	hilos	cem.	5-	19-12	Wester	nport,	MD
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	211	22.	Name and Addre	ess of Facility F1	redlock	Funer	al Hom	ne
	40260	Ш	23a. Part 1. Enter the disease, or complication			1 Jones		edmont		6750	
			shock, or heart failure. List only one cau	se on each line.				or respiratory ar	1631,	Inte	roximate rval Between set and Death
print.	Physician/ Medical		disease or condition resulting in death)	Due to (or as a consequ	igne	Strok	٤				
~/	Examiner			Due to (or as a consequ	en G 01).						
		iner	Sequentially list conditions, b. — if any, leading to immediate	Due to (or as a consequ	ence of):						
	cuted nd transit	kam	Cause (Disease or injury that initiated events c								
	e exection a sign a nurial-	al E	resulting in death) Last	Due to (or as a consequ	ence of):						
8760	death certificate be executed the attending physician and ed for use as the burial-transit	Medical Examiner	d								
89	ag d ≝	-		yes, outcome of pregnar					23d D	ate of delivery	
Вох	ss that the death certi igned by the attendin be detached for use	Physician/	in the past 12 months?	☐ Live Birth 2 ☐ Feta ☐ Pregnant at time of d		Ectopic pregnan Other (specify)	cy		- 1	onth Day	Year
о П	the d	hys	9 Unknown 9	Unknown							
P.O.	s that gned I	ρ	Part II. Other significant conditions contribu	ting to death but not resu	ulting in the ur	nderlying cause gi	iven in Part I.			tribute to the car	
ds,	require been sig should b	ted						1 🗆	Yes 2 No	3 Probably	4 K Unknown
00	law re nas be e 2 sh	Completed						24a. Was auto	psy	Were autopsy fi	
Be	cate has	Cor						1 🗆 Yes	ormed? 2 No	death? 1 Yes 2	No
ta	sician: The certificate irector, pag	Be	25. Was case referred to medical examiner?	al:		Oth	lace of Death (Che	ck only one)			
<u></u>	Physician: r this certifica aral director,	<u>ان</u>	1 Yes 2 No	1 Inpatient 2 Ba. Date of injury	ER/Outpatient 28b. Time of	28c. Injul	4 LJ Nursing F	1	dence 6 Oth		
n o	tending I leath. or: After the funer	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	wor	k? Yes 2 No	Zou. Describe	low injury occur	160	
Division of Vital Records,	of a death after death Director: A d in by the f	Certificate:	3 Suicide 6 Could not be	e. Place of Injury - At ho		et, factory, office				per or Rural Rout	e Number,
.≥	pital or burs afte eral Dir filled in			building, etc. (Specify)				City or To	vn, State)		
	Hospi 4 hou Tuner cely fill	edical	29a. Certifier 1 Certifying Physician: (Check 2 Medical Examiner: O								and manner stated.
	To the Hospital or Attending Physician: The law requires that the within 42 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Me	only one) 3 Certifying Nurse Prace 29b. Signature and title of certifier				the time, date and p		the cause(s) and	manner as stated	l
	7 W W	,	255. Signature and the or certifier	V. WAi	M.D.		4 55		5716	ed (Month, Day,)	redr)
		10	30. Name and address of person who comple	ted cause of death (Item			(5)		- ,	,	
	4	VA	AR DALAN ENKESA				Pook R.D.	-COMBE	RLAND	MD. A	2/502
	Stat		31. Date filed (Month, Day, Year) MAY 2 1 2012	2. Registrar's Signat		e)					
	Registra	Ti		Charles A.	4000						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First Middle, Last) metton Roberta 2100pm May Physician/ NO Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Columb Howar Howard County General 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 💢 F Director 213 38 8033 04-02-1918 Kentucky 94 28a-f show 10d. Inside City Limits 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10a. State 10b. County Director 1 Yes 2 No Ellicott City MD Howard 10g. Citizen of What Country? 10e. Street and Numbe Funeral United States 21042 12679 Golden Oak Drive ral", or items? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: White "natural", Completed 3 ₩ Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than College (1-4 or 5+) Elementary/Secondary (0-12) the Education Teacher other Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Mary Jane Hughes William Bradley Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12679 Golden Oak Drive Ellicott City, MD 21042 Jane E. Mooney/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 5-19-2012 Bel Air, MD Bel Air Mem. Gard. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ neumonia disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year signed by the at d be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be 1 Yes 2 No 术 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniury 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fi Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

.5

Registrar DHMH 17 Rev 06-2011

State

Medical

29a, Certifier

only one)

x12an

31. Date filed (Month, Day, Year,

3 [29b. Signature and litle of cortifier

Mode

MAY 17

UND 30-Name and address of person who completed cause of death (Item 23a) (Type, Print)

Begistrar's Signature

10

Hellicein

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) May 15th 2012

bea MD 21044

12-03968 Gerald McGrath Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

erald McGrath		1	State of Maryland / Department of Health and Mental Hygiene												
			1- For Stata Registrar		Ce	rtificate of	Death					eg. No. 2	01	2	75
Physician/ ledical Examiner			1. Decedent's Name (First, Middle,Last)								Date of Deat Month	Day Yea	r	3. Time of	
			odata Robert Heerath								May 25, 20		f Dooth	1532	ırs
			2380 Southwind Circle		4b. City, Town, or Location of Death Dunkirk					4c. County of Death Calvert					
	Funeral		Social Security Number	7. Aq	e (In vrs. i	ast birthday)	If Under		If Under:	24Hrs.	8. Date of 8irt	h(MM/DD/YYYY	9. 8ir	thplace (Sta	te or
	Director			M 2 F			Months		Hours	Min.			Foreig	ın	
			Usual Residence of Decedent	VI ZLF		18 Yrs.	· I				08/02/	/1963	Wa	shing	on, Do
	th the Maryland 23a or 28a-f show any notified at once.	Director	10a. State 10b. County		10c. City	, Town or Locati	ion							10d. Inside	City Limits
			MD Calvert		Dur	kirk								1 Yes	2 X No
			10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?												
ļ		Ę	2380 Southwind Circle 20754								7.	Inited S	.		
	with ns 23 be no	eral	11. Marital Status	12. Was Decedent			s Deceden	of Hispa			ify Yes or No-	14. Race	- Ameri	can Indian,	8lack,
1	death r iter	Fune	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No							White	, etc.				
4	after	by F	3 Widowed 4 Divorced in res, give year 1 Yes 2 X No specify:							Specify: White					
	Exam		15. Decedent's Education (Specify only			16a. Decedent	t's Usual O ost of worki					16b. Kind of Bu	siness/I	ndustry	
မ္တ ်	n 72 nan " lical I	plet	Elementary/Secondary (0-12)	College (1-4 or 5	5+)			-			·				
8	permit, Pages 1 and 2 should be lited within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Completed	17. Father's Name (First, Middle, Last)	1		Marine	Tecr			Nama /E	iest Middle M	Marine		chanic	S
<u>.</u> برگ		Be C													
21215-0036		To B	Paul L. McGrath Jean F. Lumsden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
A S			Susan K. McGrath	- Wife		2380	South	wind	d Cir	cle	Dunki	rk, Mar	v1a:	nd 207	754
ø.			20a. Method of Disposition	1		Place of Disposi crematory or oth	tion (Name	of ceme	tery,		Date	20c. Location -	City or	Town, State	-
Baltimore,			1 Burial 2 Cremation 3 Donation 5 Other Specify:	Removal from Sta		•				E /0	0/10	33			
喜		l X													
m ;	E. E. D. Se	g (g	22. Name and Address of Facility Rausch Funeral Home, P. A. P. O. Box 600, Lusby, Maryland 20657											А.	
	ysician		23a. Part I. Enter the disease, or complication failure. List only one cause on each	cations that caused	the death	Do not enter the	e mode of	dying, su	ch as card	diac or re	espiratory arre	st shock, or hea	n)	Approxim	ate Interval Onset and
	/ledical aminer		Immediate Cause (Final disease a. Intoxication												
			or condition resulting in death) Due to (or as a consequence of):												
		er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):												
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7	cured nd transit	Exa													
), be evenited	Ø (4	edical	IX UNPENDED AMENDED 23a,27,28a-f,per me,g928 6-8-12 sm												
		edi	IF FEMALE:	23c. If yes, outcom								22d Date of	dolivoo		_
87	eath ceruncate attending phy for use as the b	ian/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth	ie of pregi	_	al death	з 🗌	Ectopic p	regnanc	y	23d, Date of o Month		ay	Year
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death. The the Funeral Director: After this certificate has been signed by the attending physici phelety filled in by the fineral director, page 2 should be detached for use as the burn		sici	1 Yes 2 No 9 Unknown O Unknown												
m j	y the	Physici	Part II. Other significant conditions	9 Unknown	hut not a	anulting in the co	adarlı ilan a		o io Dani I		Tago Did tob	pacco use contrib	uto to t	he seven of	dooth?
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Š	been sig	ted					-		-	_	24a, Was ar			opsy finding	
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Division of Vital Records,	certificate	Completed									1 ✓ Yes 2		✓ Ye	s 2	No
雪	his certifi director,	Be	25. Was case referred to medical examiner?	spital:				I O+	Death (Ch				ī		
<u> </u>	er this	ပ္	1 Yes 2 No 27. Manner of Death	28a. Date of Injur		ER/Outpatient 28b. Time of In			at Work?			Residence 6		Scene	
O L	th. r: After t	io	1 Natural 5 Pending	(Month, Day,Ye	ar)			_	2 x N			ingeste		edica	tions
isio	rector:	g	2 X Accident Investigation	28e Place of Init		fd 03:5	ч рщ					reet and Numbe			
<u>.</u>	spiral or lours after neral Dir filled in	Certification:	determined (Specific)								or Town, State) 2380 Southwind Cir. Dunkirk, MD.				
Повп	within 24 hours after To the Funeral Dire completely filled in b		29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
S the	vithin 24 h To the Fur completely	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
	- 2 - 0	Ž										9d. Date signed (Month, Day, Year)			
			1/1/1/		>	10	///	D.C.M.	E.			May 26, 20	12		1
			30. Name and address of person who completed cause of death (Item/23a)												
		لب		ssistant Medic			v. Baltin	nore St	reet, Ba	altimor	e, MD 212	23			
	St Regist	ate trar	31. Date filed (Month, Day Year) 9 70	19 Server	-	A. Sa	Mad								

12-03925	
Joel Colgan Orr	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

oel Colgan Orr		1- For State Registrar	ite of Maryland	-	rtment of <i>tificate of</i>		n and	Menta	al Hy		eg. No.	201	2	757
Physici		Decedent's Name (First, Middle							2	2. Date of Deat	h Dav	Year	3. Time of	
Medical Exami	ner	Joel Colgan 0: 4a. Facility Name (if not institution	CT give street and number)		lb. City, To	wn. or Lo	cation of	Death	May 23, 20	012	nty of Dear	1503	nrs
		79 Mountain Road	,	,		Rising					Cecil	., .,		
Funeral		5. Social Security Number 6	6. Sex 7. Ag	je (In yrs. Ia	st birthday)	If Under		If Under	_	8. Date of Bird	th(MM/DD/Y)	YY) 9. Bi Fore		ate or
Director		216-39-1972	1XM 2 F		18 Yrs.	Months	Days	Hours	Min.	07/17/	1993		ountry) 1	1D
any		Usual Residence of Decedent 10a, State 10b, County		10c. City.	Town or Location	on							10d Inside	e City Limits
B	_	MD Cecil			ng Sun									s 2 X No
Maryland 28a-f show d at once.	Director	10e, Street and Number				10f. Zip C	ode			10	Og. Citizen of	What Cou	intry?	
the Man 's	ū	79 Mountain Rd	•			219	11				USA			
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er dear				X No		Yes 2X					Specia	1.71	ite	
ours aft ntural	d by	15. Decedent's Education (Specif	or Dates:	npleted)	16a. Decedent	's Usual O	cupation	n (Give kir			16b. Kind of	· y ·		
136 hin 72 hou than "nat edical Exa	lete	Elementary/Secondary (0-12)	College (1-4 or		710.00	st of working	-			d)	,,			
within piene.	Completed	10 17. Father's Name (First, Middle, L			Environ	menta				First, Middle, M			uring	
21215-0036 21215-0036 Jold he filed within 72 hours after death with the Maryland Mental Hygiene. marked nither than "natural", nr items 23a nr 28a-f sho ie event, the Medical Examiner must be notified at once.	Se C	Joseph Wilson O	17.0				- 1		,	e Wiley	Specific Artist	me)		
D 21215-D036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked ather than "natural", ar items 23a nr 28a-f she natic event, the Medical Examiner must be notified at once	70 E	19a. Informant's Name/Relationshi			19b. Mailing	Address				ral Route Num		own, Stat	e, Zip Code)	
MD nd 2 sho alth and m 27 is		Joseph W. Orr I	II/ Father	Look D						Sun, M			T	
Baltimore, MD 2/ permit. Pages I and 2 should Department of Health and Me Important: M item 27 is ma injury or nather franmatic er		1 Burial 2 Cremation	3 Removal from St	ate cr	lace of Disposi rematory or oth	er place)		5	/30	712			r Town, State	,
Lim it. Pag rtant:		4 Donation 5 Other Spe 21. Signature of Funeral Service	cify:	We	st Nott						Colora	i, MD		
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876 Tificat ing phy as the	M/u	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor	ne of pregna	. —	al death	3	Ectopic p	regnand	;у	23d. Date Month	of deliver	y Day	Year
Box 6876 e death certificate the attending phy ed for use as the b	Physician/N	1 Yes 2 No 9 Unkn	own 9 Unknown	time of dea	oth 5 Oth	er (Specify	<i>'</i>)							
Ched	Phy	Part II. Other significant conditio		h but not res	sulting in the ur	nderlying ca	ause give	en in Part	I.	23e. Did to	bacco use co	ntribute to	the cause o	f death?
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rds v requi	ete									24a. Was a			utopsy finding	
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Vision Atternation of the Attern	fica	2 Accident Investi 3 X Suicide 6 Could	28e Place of In		fd 2:15 me, farm, street		ffice buil	ding, etc.		Bf. Location (S	treet and Nur	mber or Ru	ural Route No	umber, City
Division To the Hospital nr Attenwithin 24 hours after death To the Funeral Director:	Certificati	4 Homicide		siden	ce					or Town, St Rising	ate) 79 M Sun, MI	ounta).	in Rd	•
he Hot in 24 h he Fun			sician: To the best of my											
Tot Tot	Medical	29b. Signature and title of certifier	and manner stated.	dii			icense n				29d. Date si			ar)
		10, 111	N. 01 -	0	>		D.C.M.		OCM	E	May 24,		,,, , o	
		30. Name and address of person w	no completed Suse of d	100	23a)				-	,				
		Theodore M. King, Jr., I					altimo	re Stree	et, Bal	timore, MD	21223			
Si Regis	ate	31. Date filed (Month, Day, Year)	32. Registra	r's Signatur	bare	,								

DAW UAChi, Patrick 5/7/12 1019
Division of Vital Records, P.O. Box 68760

				se Type or AMEND State o	Print in TTEM#2 f Marylar			k Ensure f Health and N	All Copies Mental Hyg	Are Leç jiene	gible.	
	Physicia Medic		State Registrar 1. Decedent's Name (First, Middle,	Last) Patrick	. Chike		rtificate of I chi	Death	2. Date of Dear Month May	th Day 07	2012	3. Time of Death 1019 M
)	Examin		4a. Facility Name (if not institution, g	give street and num.			1	r Location of Death Bethesda	1	4c. Count	y of Death	tgomery
	Funeral Director		5. Social Security Number 501-42-0034 Usual Residence of Decedent	5. Sex 1 🗶 M 2 □ F	7. Age (In yrs.)		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Countr	ace (State or Foreign y) igeria
	1 and 2 should be filed within 72 hours after death with the Maryland freath and Mental Hygiene. If Health and Mental Hygiene. If marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Examiner must be notified at	al Director	10e. Street and Number	tgomery		ty, Town or Lo		ilver Spr		10g. Citizen of	What Count	
36	after death wit al", or items 23 xaminer must	d by Funeral	3507 Sheffield 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed For 1 Yes If Yes, Give	dent Ever in U. ces? 2 X No	S. 13.	Was Decedent of H If Yes, specify Cub: 1 Yes 2 X No	20904 dispanic Origin? (Spran, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		Nige ce - America ck, White, et	n Indian,
21215-0036	vithin 72 hours iene. r than "natura the Medical E	Completed	15. Decedent (Specify only highes: Elementary/Secondary (0-12)			(Give	edent's Usual Occup kind of work done DO NOT use retired, Profe	during most of work	ing	16b. Kind of E	Business/Ind	<u> </u>
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	e 2 = 5		Chukwudi Onwuachi 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	Saunders/Da	20b. I	5254 Place of Disp cemetery, cre	Pooks Ha	ill Road,	Bethesd	,	<i>s</i> land	20814
Baltimore,	permit. Page Department o Important: If any injury or once,		4 Donation 5 Other (Sp. 21. Signature of Funeral Service Lic		1015 th	64 2	Compound 2. Name and Addre		nes-Rina	ldi Fur	reral	Home, Inc.
1	h, ici. Medical Examiner		23a. Part 1. Enter the disease, or of shock, or heart failure. List on immediate Cause (Final disease or condition resulting in death)	ly one cause on each		ymphom		ng, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
	an and rijel-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate the cause first under the cause (Disease or injury that initiated events resulting in death) Last	с	or as a conseq or as a conseq	,						
P.O. Box 68760	ne death certificate be in the attending physicie ched for use as the but	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		3irth 2 ☐ Fet nant at time of	al death 3	☐ Ectopic pregnan	су			ate of deliver	ry Day Year
rds, P.O	requires that the death been signed by the atte should be detached for	by	Part II. Other significant condition	s contributing to de	eath but not res	sulting in the	underlying cause gi	iven in Part I.	1 □ Y	es 2 🗶 No	3 🗌 Prob	e cause of death?
al Reco	ian; The law r rtificate has b ctor, page 2 s	Be Completed	25. Was case referred to medical examiner?				26. P	lace of Death (Chec	24a. Was a autop: perfor 1 \sum Yes k only one)	sy med?		sy findings available apletion of cause of
Division of Vital Records,	Io the Hospita or Attending Physician; The Taw requires that the Your after december 3 to the Funeral Director. After this certificate has been signed by the funeral Director. After this certificate has been signed by the funeral director, page 2 should be detach.	Certificate: To E	1 ☐ Yes 2 🔀 No 27. Manner of Death 1 ② Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigs	28a. Date of (Mont		ER/Outpatie 28b. Time o injury	wor	4 ☐ Nursing H	ome 5 Residence 28d. Describe ho			
Division	spital or Atte ours after de ieral Directo filled in by th		3 Suicide 6 Could n 4 Homicide determin	ed 28e. Place buildir	ng, etc. (Specif	y)	reet, factory, office	ne, date and place, a	28f. Location (Si City or Town	n, State)		
	No the Hos within 24 h	Medical	(Check 2 Medical Ex	aminer: On the bas	s of examination To the best of	on and/or inve my knowledge	stigation, in my opini	on, death occurred a the time, date and pl	at the time, date ar ace, and due to th	nd place, and di ne cause(s) and 29d. Date signe	ue to the cau manner as st	se(s) and manner stated. tated. lay, Year)
			30. Name and address of person w Steven Wilks, N	.D., 860	e of death (Iten	eorge	town Road					
	Sta Registra	te ar	31. Date filed (Month, Day Year)	112 Lens	egistrar's Signa	ture fa	N. J					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Lena Henrietta Puddy 756 Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death **Examiner** County of Death Cumber Allegance Kegional Medical If Under 1 Year If Unde 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) February 24, 1925 **Director** 158-16-4094 87 New Jersey Usual Residence of Decedent or 28a-f show 10b. Count 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 464 Walnut Drive Funeral 21532-U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify. "natural", Specify: Completed 3 X Widowed 4 Divorced White other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) 12 Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Karl A. Schindler Mary B. Simpson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sl of Health a item 27 is William C. Puddy 21532-464 Walnut Drive Maryland Frostburg Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 1 Burial 2 X Cremation 3 Removal from State injury or Department of Important; If any injury or Cumberland Crematory May 17, 2012 Cumberland Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lice see 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_ysician repro Voiscu disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury burial-trai that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical Box 68760 IF FEMALE: nse yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗷 No for Day Pregnant at time of death Month Year 5 Other (specify) the signed by the P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has blirector, page 2 s autopsy performe Yes 2 X No 2 No Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 🗌 Yes 2 XNo Other: မ 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check ertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29c. License number DO0 33280 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16134 ìL Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Ma	aryland / Dep			∕lental Hygi	ene	
			State Registrar		Ce	rtificate of l	Death	T	g. No. 20	2 17576
Ī	Physicia Medic		1. Decedent's Name (First, Middle, La Gertrude	Leona	Po	rter		2. Date of Death	15 20	3. Time of Death
-	Examin		4a. Facility Name (if not institution, giv Western MD Regio	,	ıl Center		r Location of Death mberland		4c. County of D	eath egany
	Funeral Director		040 01 7045		e (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) 03/22/1	9. (ear) 9. Ma	Birthplace (State or Foreign Country) aryland
	aryland a-f show fied at	ector	10a. State 10b. County	egany	10c. City, Town or Lo	ocation umberland			,	10d. Inside City Limits
	with the Ma 23a or 28 ust be noti	Funeral Director	10e. Street and Number 11218 Kansas A			10f. Zip Code 215	02	10	og. Citizen of What USA	
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 ☐ Never Married 2 【X Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates.	No	Was Decedent of H If Yes, specify Cuba 1 Yes 2 X No	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Black, W	merican Indian, Ihite, etc. White
Maryland 21215-0036	vithin 72 hour liene. er than "natu the Medical	Completed by	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)	Education	(Give life. D	dent's Usual Occup kind of work done (O NOT use retired) Omemaker	ation during most of work	ing 1	6b. Kind of Busine	
land 2	d be filed v Aental Hyg irked othe tic event,	To Be	17. Father's Name (First, Middle, Last) Hayes	Gord	on		18. Mother's Nam Margare	e (First, Middle, Ma t	uiden Surname) Po	owell
, Mary	and 2 should Health and N tem 27 is ma other trauma		19a. Informant's Name/Relationship (Lester E. Porter		sband 19b. Maili	ng Address (Street : 18 Kansas	and Number or Rura Avenue,	Route Number, C Cumberla	City or Town, State, and, MD	Zip Code) 21502
Baltimore,	Page 1 ar ment of He ant: If iten ury or oth		20a. Method of Disposition 1 K Burial 2 Cremation 3 4 Donation 5 Other (Spec		Restlawn	matory or other place Mem. Gard	ens 05/1	8/2012	Oc. Location - City LaVale,	MD
Balt	permit. Departi Import any inji		21. Sgnature of Funeral Service Licer)(SG					Ly Funera Land, MD	11 Home, P.A. 21502
	Physician/ Medical Examiner		23a. Part 1. Soter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line. a. MEMSTI	the death. Do not enter. The SIL a consequence of):				ia	Approximate Interval Between Onset and Death
	ecuted and Il-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last	C	a consequence of):					
260	cate be exphysician	edical		d						
P.O. Box 687	ie death certificate be executed r the attending physician and ched for use as the burial-trans	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 【No 9 ☐ Unknown	23c. If yes, outcome of Live Birth 2 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregnand Other (specify)	y		23d. Date of o	delivery Day Year
ls, P.0	uires that the dea n signed by the a uld be detached t	by	Part II. Other significant conditions	contributing to death bu	ut not resulting in the u	inderlying cause giv	en in Part I.			to the cause of death?
Division of Vital Records,	the Hospital or Attending Physician. The law requires that the hut. 44 hours after death, the Funeral biter death, the Funeral bitercorr. After this certificate has been signed by the projector. After this certificate has been signed by the project of the funeral director, page 2 should be detach applied in by the funeral director, page 2 should be detach.	Completed						24a. Was an autopsy performed 1 Yes 2	prior t ed2 death	autopsy findings available to completion of cause of ? Yes 2 \sum No
ta	sician: The certificate rector, pag	Be (25. Was case referred to medical examiner?	Hospital:			ace of Death (Check			
of Vi	ing Physic frer this cuneral dir	ate: To	1 ☐ Yes 2 ☒No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending	1 X Inpatie 28a. Date of injury (Month, Day,			4 □ Nursing Ho at	me 5 Residence 28d. Describe how	ce 6 Other (Sp injury occurred	pecify)
ivisior	or Attending P safter death. I Director: After t d in by the funers	Certificate:	2 Accident Investigatic 3 Suicide 6 Could not 4 Homicide determined	be 28e Place of Injur	rry - At home, farm, str . (Specify)		Yes 2 No	28f. Location (Stree City or Town, S		Rural Route Number,
Ω	To the Hospital or within 24 hours aft. To the Funeral Dir completely filled in	Medical	(Check 2 L Medical Exam	ysician: To the best of miner: On the basis of ex	kamination and/or inves	tigation, in my opinic	n, death occurred at	the time, date and	place, and due to th	ne cause(s) and manner stated.
	To the To the comple	Σ	only one) 3 L Certifying Nul 29b. Signature and title propriifier	rse Practitioner: To the	s best of this knowledge	29c. License	number	290	cause(s) and manner d. Date signed (Mon	nth Day Year
	SUS		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type, F	Print)				
	Stat Registra		31. Date filed (Month, Day, Year) NAY 1 6 2012	`	r's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:58 AM Margaret Pogodzinski Agnes 2012 Mas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Lions Center for Rehab & Ext Care Cumberland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Min. Days Hours 362-28-8440 Director 11/04/1922 Michigan permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits aţ Director or 28a-f s notified Detroit 1 X Yes 2 No Wayne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 48234 19957 Packard Street USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Yes, Give 3 X Widowed 4 Divorced White Completed Year or Dates. Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) 77 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Correctional Institute Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Stanley Ronewicz Bernice Skladowska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Gates / Daughter 2015 Frostburg Road, Frostburg, MD : If item 27 or other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Resurrection Cemetery 05/18/2012 Clinton Twp, MI 4 Donation 5 Other (Specify) \$it nettine of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 21502 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Caranon disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live Birth
4 Pregnant a
9 Unknown 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 Other (specify) Pregnant at time of death the be detached ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nhknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perform 1 Yes 2 No 1 ☐ Yes 2 🔀 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 24 hours after death. Funeral Director, A Accident Investigation in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled Medical 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho
To the Fune
completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one 29b. Signature and title of 29d. Date signed (Month, Day, Year) 00033280 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

nds

WD

32. Registrar's Signature

625 Kent Avenue, Cumberland, MD

Please Type or Print in Black Indelible Ink2 Ensure All Copies Are Legible.

			For State Registrar	State of Maryla		artment of F rtificate of L		and Mer		ene 201	2	17578
	Physicia Medic		1. Decedent's Name (First, Middle, Last EDWARD	GILBER	Г	PLOURDE	III		Date of Death	,2012 Ye	or	Time of Death 7:23P M
	Examir		4a. Facility Name (if not institution, give s FREDERICK MEMORI			4b. City, Town, or FREDER		f Death		4c. County of E FREDE		
	Funeral		5. Social Security Number 6. Sex		last birthday)	If Under 1 Year Months Days	If Under 2 Hours		Date of Birth Month, Day, Y	9. (ear)	Birthplace Country)	e (State or Foreign
	Director		219-90-7551 Usual Residence of Decedent	M 2 □ F 49	Yrs.				8/22/1		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	VA
	ryland I-f show ied at	Director	10a. State 10b. County		ity, Town or Lo							Inside City Limits
	the Ma or 28a e notif	Dire	MD Freder: 10e. Street and Number	LCK M	t. Air	10f. Zip Code			10	g. Citizen of What		1 Yes 2 No
	h with 1s 23a nust b	Funeral	6114 A. Woodville	e Rd.		21771				USA	,	
36	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🔼 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 🄼 No	n, Mexican,	in? (Specify ` Puerto Ricar	Yes or No- n, etc.)	14. Race - A Black, W Specify:	/hite, etc.	
Maryland 21215-0036	2 hours "natur dical E	Completed	15. Decedent's Edi (Specify only highest grad			dent's Usual Occupa		of working	10	ôb. Kind of Busine	Whi ess/Indust	
121	ithin 72 ene. r than	Com	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. D	O NOT use retired)	uning most	or working		constru	ation	•
nd 2	filed wall Hygi	Be	17. Father's Name (First, Middle, Last)			arpenter	18. Mother	r's Name <i>(Fir</i> s	st, Middle, Ma	iden Surname)	CLIOI	
Z	should be file and Mental I is marked o raumatic eve	To	Edward Gilbert Plo				Caro	lyn Ke	enan			
Ma	12 sho alth and 27 is r r traun		19a. Informant's Name/Relationship (Type Edward Plourde,		11	ng Address (Street a)
Baltimore,	permit. Page 1 and 2 s Department of Health Important: If item 27 any injury or other tra		20a. Method of Disposition 1 Burial 2 Cremation 3 F	20b.	Place of Dispo	sition (Name of natory or other plac		Date		C. Location - City		State
<u>Ŧ</u>	it. Page intment intant: I		4 Donation 5 Other (Specify)	St	auffer	Cremator	у			rederick		
Ba	permi Depar Impo any ir		21. Signature of Figure 2 Service License	mye	2 22	Name and Address Opos	ss of Facility sumtov	Stauf vn Pik	fer Fu e, Fre	neral Ho derick,	mes, MD 21	P.A. 702
J	Ph _y sician Medical		23a. Part 1. Enter the disease, or complishock, or heart failule. List only one Immediate Cause (Final disease or condition resulting in death)	e cause on each ine.	ic.	er the mode of dying			piratory arrest		Inte	proximate erval Between set and Death
1	Examiner			Due to (or as a consec Cardia	uence of):	itiest	Al.	nsati	stick)		1-	- 2 days
	p ##	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq		700.						N
	xecute n and ial-trans		Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	juence of):							
09/	certificate be executed nding physician and use as the burial-transit	edical		I								
X P P	death certif ne attending ed for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	3c. If yes, outcome of pregn: 1 □ Live Birth 2 □ Fet 4 □ Pregnant at time of g □ Unknown	al death 3	Ectopic pregnanc Other (specify)	у			23d. Date of Month	delivery Day	Year
	uires that the n signed by the	è	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.			cco use contribute		
Vital Records,	law has je 2	Completed						_	24a. Was an autopsy performe	d? prior death	to comple	indings available tion of cause of
Ita I	ician: certifica rector,	Be	25. Was case referred to medical examiner?	ospital:		Tau		(Check only		A NOT	163 2	1110
01 <	g Phys er this eral di	e: 1	27. Manner of Death	1 Anpatient 2 28a. Date of injury	28b. Time of	t 3 DOA Othe	4 Nur			e 6 Other (Sp.	pecify)	
0	eath. or: Aft	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year)	injury	M 1 □	? Yes 2□N	- 1		,,		
DIVISION	ital or Atturs after dral Direct		4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	y)				City or Town, S			te Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director. After this certificate completely filled in by the funeral director, pag	Medical	(Check 2 Medical Examine only one) 3 Certifying Nurse	tian: To the best of my knower: On the basis of examination Practitioner: To the best of	n and/or invest	igation, in my opinio	n. death occ	urred at the ti	me, date and p	place, and due to the	ne cause(s)	and manner stated.
	7 wit		29b. Signature and ditle of certifier)		29c. License D 72	number 97	7	29d	Date signed (Mo	2017	Year)
			30. Name and address of person who co	npleted cause of death (Iten	1 23a) (Type, P	rint) 'cdinick	MI)				
	Stat Registra	9	31. Date filed (Month, Pay Year) 6 20	32. Registrar's Signa	ture .	ares	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2012 Physician/ 12;35 PM Karen Ronnell Payne May 14, Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Snow Hill Worcester 108 Powell St. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours Min (Month, Day, Year) 175-56-9876 Director 1 M 2 X F 51 01/08/1961 Maryland Usual Residence of Decedent f show Department of Health and Mental Hygiene. Important if items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than most be notified at once. 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Maryland Worcester Snow Hill 1 🙀 Yes 2 🗌 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 21863 USA 108 Powell St. 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc. þ 1 Never Married 2 XMarried 1 Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Vacation Rental Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Page 1 and 2 should be ment of Health and Menta Emma K. Bildhauer MacCubbin F. Ronald Woodsum 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Powell St., Snow Hill, MD 21863 Leon S. Payne/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/16/2012 Salisbury Crematory Salisbury, MD 22. Name and Address of Facility
Holloway Funeral Home Professional Association 21. Signature of Funeral Service Pocomoke City, Part 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and Exami for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 Other (specify) Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 22 No 3 Probably 4 Unknown 1 Yes completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: မ 1 🗆 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify, 27 Mapner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending injury Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I 3 🗌 only one 29b. Sier 29d. Date signed (Month, Day, Year,

DHMH 17 Rev 06-2011

State Registrar 23a) (Type, Print)

Name and address of person who completed cause of death (Item

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Deste

32.

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month May Physician/ 16ª 3:59 AM REGINA POPE В. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Laurel Regional Hospital Prince George's Laurel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Hours New Jersey Aug:10,1937 147-28-7550 74 Director 1 🗆 M 2 🔀 F 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** Beltsville notified Maryland Prince George's 1 🗆 Yes 2 🖁 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō þe must be 20705 United States 3404 Dunnington Road items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, "natural", or iter Armed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed er than "natur the Medical I 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 1-4 Elementary/Secondary (0-12) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the Nonce. US Catholic Conference Administrative Assistant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alice Tolland William A. Goetzl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3404 Dunnington Road Beltsville, Maryland 20705 James E. Pope, Jr. -husband 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory5/16/2012 |Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Dônald Vdr Borgwardt Funeral Home, PA Worald 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pleyral Ph_sician/ Malignant disease or condition Medical resulting in death) Examiner Edema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last the burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certificate: To Be Completed by Bladder Cancer 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t director, page 2 s autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical director, 26. Place of Death (Check only one) Other: 1 ☐ Yes _ 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred After injury 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: Algoripletely filled in by the fu Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7 700 2012 16 7300 Van Dusen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road Saritha Gorantla, Laurel Regional Hospital 20707 aurel 31. Date filed (Month, Day, Year) State

Registrar

MAY 17

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Records,

Division of Vital

HIEN NEUTEN, 6104 Old Branch Avenue, Temple Hills, MD 20748

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Day, Year)

MAY 17

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G928 6/04/2012 JH. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 22:15 M Month Physician/ illiam 05 Harris Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Maryland nder 24 Hrs. 8. Da Mary land seomes Haspital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months 224-94-0316 Director 1 X M 2 □ F 52 17 inginia Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location with the Maryland the Medical Examiner must be notified at Director 1 Yes 2 No Virginia Alleahani torge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral items 23a permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1 XYes 2 □ No
If Yes, Give Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced African-American Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) House parent Home 2045 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည unior H. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherry Elkton, Virginia 22827 Koss 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burlal 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date tarrisonburg, Virginia 5/23/2012 Cornation Sorvice 4 Donation 5 Other (Specify) Harrisenburg Carnation Strvice. 21. Signature of Funeral Service Cense Bent 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, VA 220 shock, or heart failure. List only one cause on each line. Trail Harrisonburg 10855 AV Approximate Myocarelial Interval Between Infaction Onset and Death Immediate Cause (Final Acute Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Be Completed by Physician/Medical Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and for use as the burial-trai Due to (or as a consequence of) nding physician Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death
9 Unknown g Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' 1 ☐ Yes 2 ☐ No 1 Yes 2 25. Was case referred to medical examiner?

1 Ves 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify Hospital ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 2 🗌 No Investigation Accident within 24 hours after death

To the Funeral Director: A 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Descripting Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5/21/2012 D0057800 MO 30. Name and address of person who completed cause of death (Item 23a) (Type Print).

MUHAMMAD HSHRAF 5711 Sasvis avenue #100 Riverdale,

DHMH 17 Rev 06-2011

State

Registrar

MUITA MM AD
31. Date filed (YUN 0, 4ª2012

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Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death ecodent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical not institution, give street and number) **Examiner** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Davs Months Hours 220-26-5955 Director 1 X M 2 D F Yrs Feb 20, 1931 Maryland 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County Medical Examiner must be notified at Director 1 🗆 Yes 2 🗓 No Boonsboro Maryland Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 items 23a Funeral 21713 U.S.A. 6228 Appletown Road death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. 9 1 Never Married 2 X Married Completed by Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗶 No Specify "natural", 3 Widowed 4 Divorced White 1953 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other the any injury or other traumatic event, the I Telephone Company 12 Serviceman Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Poffenberger Mabe1 Mary Ralph William Reeder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 6228 Appletown Road Boonsboro, Maryland Betty J. Reeder/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 🛚 Burial 2 🗆 Cremation 3 🗆 Removal from State Zion Locust Grove 05-25-2012 Rohrersville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Feranservice License 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA 21713 7606 Old National Pike Boonsboro, MD ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Part 1. Enter the disease, or complicat shock, or heart failure. List only one Approximate Interval Between Onset and Death 23a. Part 1 Immediate Cause (Final Physician/ Stansis disease or condition resulting in death) Medical Due to (or as a consequence of Examiner acteremic Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by funeral director, page 2 should be 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No certificate 26. Place of Death (Check only one) 25. Was case referred to medical 2 No Hospital 1 Anpatient 2 ER/Outpatient 3 DOA
Date of injury
(Month, Day, Year) 28b. Time of injury ဂ္ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) After this Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work?
1 Yes within 24 hours after death.

To the Funeral Director: A: Accident Investigation Suicide 6 🗌 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completely (Check Certifying Nyrse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the only one 29b. Signature 2012 as of person who completed cause of death (Item 23a) 30. Name and TN-10+ Kek: egistrar's Signature 31. Date filed (Mont) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ LBD A Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4c. County of Death Koay lan M e cu Garre Social Security Number 8. Date of Birth (Month, Pay, Year) 9. Birthplace (State or Foreign Country) MD **Funeral** 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. Months 216-66-2292 79 **Director** 1 🗆 M 2 🔀 F ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🕱 No MD Garrett Swanton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 111 Sweitzertown Road 21561 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after death Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Divorced 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Pauline Carroll Joseph Gilpin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Edward Rexroad / Husband 111 Sweitzertown Road, Swanton, MD 21561 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) 5/18/2012 Swanton, MD George Cemetery Signature of Funeral Service Licenses 22. Name and Address of Facility Burdock-Fredlock Funeral Home, P.A. 21 North Second Street, Oakland, MD 21550 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Physician/ Medical **Examiner** Be Completed by Physician/Medical Examiner burial-transit ed by the attending physician detached for use as the buria Medical Certificate: To

the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. Division of Vital Records, P.O. Box 68760

Immediate Cause (Final disease or condition resulting in death)	a. Metastat & Breast bue to (or as a consequence of):	Onset and Death Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
		24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1	ack only one) Home 5 ☑ Residence 6 ☐ Other (Specify)
27. Manner of Death Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury at work? M 28c. Injury at work? 1 Yes 2 No	28d. Describe how injury occurred
3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
(Check 2 Medical Exami	sicians: To the best of my knowledge, death occurred at the time, date and place, iner: On the basis of examination and/or investigation, in my opinion, death occurred se Practitioner: To the best of my knowledge, death occurred at the time, date and	at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier Pantpa	29c. License number 17 76 1	54 29d. Date signed (Month, Day, Year) 5 / 16 / 20 / 2
30. Name and address of person who o	completed cause of death (Item 22a) (Type, Print) 69 Wolf A	enes Dr Odkland MD
31. Date filed (Month DayYear 7	32. Rigistrar's Signature	2155

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

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Annette Theodore Samaras	State of Maryland / Department of Health and Mental Hygien
1. For State	On the state of Daniel

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		1- For State Registrar		Certifi	cate of	Death			Reg. No) [(1750
Physici		1. Decedent's Name (First, Midd						2. Date of D Month	eath Day	Year		3. Time of Death
ledical Exami	ner	Annette Theodo			14	h City Town	ar Looption of I	May 21	2012		f Dooth	2133 hrs
		1607 Virginia Street	in, give street and number)		14	b. City, Town, o Annapolis	or Location of i	Death	- 1	tc. County o Anne Art		
Funeral		Social Security Number	6. Sex 7. Ag	e (In yrs. last b	irthday)	If Under 1 Ye	ear If Under 2	24Hrs. 8. Date of	Birth(MN	M/DD/YYYY)	9. Birtl	nplace (State or
Director		216-22-3069	1. M 2XF		86 _{Yrs.}	Months Da	ys Hours	3.01m		,1926	Foreign	
		Usual Residence of Decedent										
' any		10a. State 10b. County		10c. City, Tow	n or Locatio	on						10d. Inside City Limits
Aaryland 28a-f show 1 at ouce.	6	Maryland Anne	Arundel	Annar	olis							1 X Yes 2 No
Maryl 28a-	Director	10e. Street and Number				10f. Zip Code			10g. Ci	itizen of Wh		•
th the M 23a or 2 10tified		1607 Virginia				2140						SA
th wit	Funeral	11. Marital Status 1 X Never Married 2 M	12. Was Decedent Armed Forces?					? (Specify Yes or uerto Rican, etc.)	No-	14. Race - White		an Indian, Black,
er dea			1 Yes 2	X No		Yes 2 X N	o specific			Specify:	Whi	te
urs aft :ural"	by	15. Decedent's Education (Spe	or Dates:	pleted) 16a				id of work done	16b.	Kind of Bus		
72 hor	Completed	Elementary/Secondary (0-12)	College (1-4 or			st of working lif						•
5-0036 ed within 7 tygiene. other than	ldu	12		Se	ecreta	ary			US	Nava	1 Ac	cademy
5-0 iled w Hygic		17. Father's Name (First, Middle,						Name (First, Middle				
21215-0036 Muld be filed within 72 hours afte Mental Hygieve marked other than "natural?" cevent, the Medical Examine	Be	Theodore Samara		12	OL 14 (II)	* ! !		rine Econ				
MD 2 d 2 shoul lith and M n 27 is m	ဥ	19a. Informant's Name/Relations Georgia Liakos						er or Rural Route N , Arnold,				
- 5 2 2 5		20a. Method of Disposition	- Davis/ Biscoi	20b, Place	of Disposit	ion (Name of c		Date		. Location -		
Baltimore, permit. Pages 1 at Department of Hee Important: If ite		1 X Burial 2 Cremation	_	St.	atory or othe Demeti	er place)	5	5-26-2012	- 1			Maryland
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Physician		23a Part Enter the disease, or	complications that caused	the death. Do	not enter the	mode of dying	, such as card	diac or respiratory	mest, sh	ock, or hear		Approximate Interval
/Medical £xaminer		failure. List only one cause Immediate Cause (Final disease	a. Atheroscl						nsiv	e		Between Onset and Death
_Adminer		or condition resulting in death)	Due to (or as a conse									
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7 60, ficate be ex g physician the burial	/Medical	IF FEMALE:	23c. If yes, outcom						122	3d. Date of c	lalivanı	
3876 rtificate ing phy as the t		23b. Was decedent pregnant in the past 12 months?		ie oi pregnanc		l death 3	Ectopic pr	regnancy		Month	Da	ay Year
Box 687; death certiff the attending cd for use as t	sici	1 Yes 2 No 9 ✔ Unk	4 Pregnant at	time of death	5 Othe	er (Specify)						
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tal Recision: The certificate ector, page		25. Was case referred to medical				26 Plac	e of Death (Ch		2	No 1	✓ Yes	2 No
/ita	Be	examiner?	Hospital: 1 Inpatie	nt 2 ER/	Outpatient		Tother —	lursing Home 5	Resid	ence 6 🗸	Other:	Scene
Division of Vital Records, s and or Attending Physician: The law requiring a Director. After this certificate has been sited in by the funeral director, page 2 should be	٦ ا	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	ry 28b	Time of Inj		ury at Work?	28d. Describ				
ion tendin eath. tor: A	흲	1 Natural 5 Pend			121:16	5 pm 1	Yes 2 🗶 No	unknow	n.			
VISI or Att fter de in by	<u>=</u>		d not be 28e. Place of Inj				building, etc.	28f. Location	(Street	and Number	or Rura	al Route Number, City
Divisior Hospital or Attend 24 hours after death Funeral Director: stely filled in by the	Certification:	4 Homicide deter	mined (Specify) Sin	gle Fan	nily H	оте		Annapo	lis	,MD.	LIGI	mia bt.
Division of Vital Records, P.O. Box 68 within 24 hours and a rectificate the treatment or Attaching Physician: The law requires that the death certificate 4 hours after detect. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		(Ollowit Brill)	nysiclen: To the best of my									
To the within 2 To the complet	Medical	2 🔻	miner: On the basis of exar and manner stated.	mination and/or	investigatio			red at the time, da				``
	2	29b. Signature and title of certifie	1 11 11	\			se number .M.E.			y 22, 201		h, Day, Year)
		ppu 1	hay. M.	J		0.0	. 191. 🕒 .		IVIA	, 22, 201		
		30. Name and address of person Melissa Brassell, MD	who completed cause of de Assistant Medical			Baltimore S	Street, Balt	imore, MD 21:	223			
St	ate	31. Date filed (Month, Day Year)										
Regist		JUN 0 4 2012	Cheen p	s Signature	-							

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Donna Jean Shriver Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Western MD Regional Medical Center Cumberland If Under 24 Hrs. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min (Month, Day, Year) May 29, 1942 69 Maryland 215-42-2604 **Director** 1 🗆 M 2 🕻 F Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State injury or other traumatic event, the Medical Examiner must be notified at Director Frostburg 1 ☐ Yes 2 💢 No Allegany Maryland ь 10e. Street and Number 13213 Upper George's Creek Road 10f. Zip Code 10g. Citizen of What Country? 1 and 2 should be filed within 72 hours after death with 1 f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a Funeral 21532-U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. or. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: White 3 X Widowed 4 Divorced Year or Dates 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 0 Dietary Cook Nursing Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Henry McKenzie Margaret Rizer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21562-Cindy Shriver Daughter 112 Kelley Avenue Maryland Westernport 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of P Important: If ite any injury or ot once. Page 1 1 Burial 2 Cremation 3 Removal from State Frostburg Memorial Park Maryland May 23, 2012 Frostburg 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licer Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onser and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last ng physician a Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ 1 Live Birth
4 Pregnant
9 Unknown this certificate has been signed by the atter ral director, page 2 should be detached for u in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 1 Yes 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform performed? 1 \sum Yes 2 \sum No 2 🗌 No 1 🗌 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2. No Hospital Other: 2 1 🗌 Yes ER/Outpatient 3 DOA 1 Inpatient 2 I 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at s after death. 28d. Describe how injury occurred 1 Natural 2 Accider injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral C completely filled Hospital Medical LE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Qetitiving Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) DOO 33280

DHMH 17 Rev 06-2011

State Registrar Cumberland,

21:4E 101

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Rebecca Hite SNYDER a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Western Maryland Hospital Center Hagerstown Washington If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M Director March 15 1959 Maryland 213-68-6732 53 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 112 S. Prospect Street 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 K No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Special Needs Labor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George E. Snyder Helen Hite 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Young - Sister 13008 Blue Ridge Road, Hagerstown, Md. 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 5/19/2012 | Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 16 alux 415 E. Wilson Blvd. Hagerstown, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to k r as a ox nsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed physician Physician/Medical the attending IF FEMALE: nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9☐ Unknown 9 Unknown Part II. Other significate Conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 No 1∐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 1 Natural 5 ☐ Pending investigation Injury 1 ∏Yes 2 ∏No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide

completely

Baltimore, Maryland 21215-0

P.O. Box 68760,

Records,

Division or Vital

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

HAHAB





and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



🕊 certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month. Dav. Year)

MAY 17

1500 Pennsylvania Avenue

Hagerstown, MD 21742

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deatl Physician/ ETHEL LOUISE SUTHERLAND MAY^{nth}8, 2012 7:20A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 064-16-3175 Hours Director 91 Yrs 1 □ M 2 🗑 F 07/18/1920 Georgia Usual Residence of Decedent s 23a or 28a-f show ust be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Frederick MD Frederick 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 21704 5955 Quinn Orchard Road Apt. 159-160 must k United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify 3 X Widowed 4 Divorced Completed Year or Dates ed other than "nature event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Radiologic Technologists Childrens Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ethel Pike Henry Houston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DeLee Yaukey / Granddaughter 20383 Mill Pond Terrace Germantown, MD 20876 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Arlington Nat. Cemet. Unknown Arlington, Virginia 22. Name and Address of Facility Joseph Gawler's Sons Inc. Signature of Funeral Service Licenses 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that initiated events Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 88 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? for Month Day Year Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA ပ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending within 24 hours after death.

To the Funeral Director: A Completely filled in by the fi Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatur 29d. Date signed (Month, Day, Year, 2 D51643 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) d1702 Frederica omas (Month, Day, Year) 2. Registrar's Signature State MAY 17 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 2012 Physician/ p^{M} Stultz Roger P. May 15 3:20 **Medical** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Columbia Gilchrist Center-Howard County Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months 215-46-1612 **Director** 1 🛛 M 2 🗆 F 64 Yrs Sept. 2, 1947 Maryland Usual Residence of Decedent ian "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10d. Inside City Limits 0a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Columbia MD Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21045 7018 Flintfeet Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

X Yes 2 No Specify. White ò 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates. 1965-71 Completed 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) I Hygiene.
I other than "
vent, the Me life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) General Sales Salesman traumatic event, Be permit. Page 1 and 2 should be filed. Department of Health and Mental Hw. Important: If item 27 is meriany injury or other: 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Maggie Jewel Holcomb Walter Noland Stultz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7018 Flintfeet Lane, Columbia, MD 21045 Denise Bracalilly Stultz/Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of May 23, cemetery, crematory or other place) 1 👱 Burial 2 ☐ Cremation 3 ☐ Removal from State Cheltenham, MD Veterans Cemetery 2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Eacility
Francis J. Collins Funeral Home Inc.
00 University Blvd. W., Silver Spring, 21. Signature of Funeral Service Licenses MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 2011 CANCER disease or condition resulting in death) LUNG Medical Due to (or as consequence of Examiner Sequentially list conditions, Examiner Due to (or as a consequence of). if any, leading to immediate
Cause (Disease or injury
that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last the attending physiciar Physician/Medical buri Records, P.O. Box 68760 as the t IF FEMALE be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 2 No 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed' 1 🗌 Yes 2 🗆 No Yes 2 No the funeral director, Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Sp. 1 ☐ Yes 2 🗷 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No 24 hours after death. Funeral Director, At Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 hor To the Fune completely f (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the only one 29b. Signature and title o 164395 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6336 CEDAR LANE DOBERMAN, MO DANIEUE 32. Registrar's Signatu 31. Date filed (Month, Day, Year) State 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 1:20a M 2012 Ina Mae Silber Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery 2 Foxhall Court Social Security Number '. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 579-40-1768 **Director** 1 M 2 X F Yrs May 06, 1931 81 Washington, DC Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f sho her must be notified at Director 1 Yes 2 X No Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2 Foxhall Court 20906 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) n "natural", or iterr ledical Examiner n 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: Specify White 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည David Newman Rose Władovsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanley E. Silber - Spouse Foxhall Court, Silver Spring, Maryland 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5 1 🗶 Burial 2 🗌 Cremation 3 🗶 Removal from State permit. Page Department of Important: If any injury or once. King David Mem.Grdns. | 05/13/2012 | Falls Church, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician Non Hodykins Lymphoma Years disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Records, P.O. Box 68760 the 35 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year Pregnant at time of death signed by the a 2 X No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law I within 24 hours after death.

To the Funeral Director: After this certificate has be autopsy 1 ☐ Yes 2 ☐ No 2 X No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 💢 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury 1 X Natural 5 Pending 1 Yes 2 No the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier 🛮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatu 29d. Date signed (Month, Dav. Year) D67258 May 11, 2012

State Registrar

DHMH 17 Rev 06-2011

MAY 17 2012

Nicholas J.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Farrell

MD, 9707 Medical Center Drive, #300, Rockville, Maryland 20850

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

feel cell

Usnakiran Yenigalla

MAY 17

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Physician/Medical

Completed by

Be (၉

Certificate:

Medical

Director

Funeral

Completed by

Be

ဥ

Physician/

Medical

Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

_ State		State of Ma	arylaria / i				4 IVIC	entai i iygi	CITE		
Registrar	. (Fi-+) 6:-1-11.			Certi	ificate of I	Death	_		g. No. 2	12	1759
1. Decedent's Nam	e (First, Middle, La REW SAUNI	·					2	2. Date of Death Month	/8/2012	Year	3. Time of Death
		e street and number)	-	T	41 O'1 T	-1 - 12 - CD		05/	 		11:17a м
	ove Hosp:				4b. City, Town, o Rockvi 1]		atn		4c. County Montq		v
5. Social Security N	_		e (In yrs. last birt	thday)	If Under 1 Year	If Under 24 H		3. Date of Birth			place (State or Foreign
578-76-41 Usual Residence of	.2 /	I 🔀 M 2 □ F	59	Yrs.	Months Days	Hours Mi	n.	12/24/	1952	CN	ew York
0a. State	10b. County		10c. City, Town	n or Loca	tion						10d. Inside City Limits
MD	Montgame	ery	Gaithe:	rsbu	rg						1 🗆 Yes 2 🗙 No
0e. Street and Nur					10f. Zip Code				g. Citizen of V	Vhat Cou	ntry?
742 Tiff	any Cour	t			20878			Ţ	ISA		
_	ied 2 Married	12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give		If Y	as Decedent of H 'es, specify Cuba	an, Mexican, Pue				k, White,	
3 Widowed	4 L Divorced 15, Decedent's E	Year or Dates.	10-		nt's Usual Occur					вта	
(Spe	cify only highest gr			(Give kir.	nt's Usual Occup Id of work done (NOT use retired)	during most of w	orking	· · · · · · · · · · · · · · · · · · ·	16b. Kind of Bu	isiness İn	dustry
	th	Conege (1-4 or 5			ities Ma		Uni	V MD I	ducati	on	
7. Father's Name (Andrew Wi	First, Middle, Last) 11iam San	unders				18. Mother's N Ethel		First, Middle, M O scomb	aiden Surname)	
	ame/Relationship (1 Ineh Sat	Type, Print) unders/wife	e 7.		Address (Street iffany (
0a. Method of Disp		-1			ion (Name of	20)	Dat	te 2	l0c. Location -	City or To	own, State
	☐ Cremation 3 ☐ 5 ☐ Other (Speci	☐ Removal from State ify)			tory or other place emorial	Pk. 5	/19)/2012 F	Rockvil	le, i	MD
21. Sign to Fu	neral Service Licen		576		Name and Addre						20850
23a. Part 1. Enter t	the disease, or com	nplications that caused one cause on each line	the death. Do r	not enter	the mode of dyir	g, such as cardi	ac or r	espiratory arres	t,		Approximate Interval Between
Immediate Cause (disease or condition	Final			fibr	illation	7					Onset and Death
resulting in death)		Due to (or as a	consequence of	of):						3.	
sequentially list co	inditions,	v. cardia	myopa	thy	withe	ection.	Frac	tion te	npercel	nT	
if any, leading to in cause. Enter Unde	nmediate rlying	Due to (or as a	consequence	of):					1		
Cause (Disease or that initiated events	s	C. Due to for co	a consequence of	of):						+	
resulting in death) l	Last	Due to (or as a	z consequence (Oij.							
		d								+	
F FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal death		Ectopic pregnand Other (specify) _	СУ			23d. Dat	e of deliv	ery Day Year
		contributing to death b	ut not resultina i	in the und	lerlying cause di	ven in Part I.		23e. Did tob	acco use contri	ibute to t	he cause of death?
							-				bably 4 🗷 Unknown
								24a. Was an		Vere auto	psy findings available
					<u> </u>			autopsy perform	ed? d	leath?	impletion of cause of
5. Was case referre	ed to medical				26. Pl	ace of Death (C/	neck or		AST INO	res	Z LI NO
examiner? 1 Yes 2	□No	Hospital:	ent 2 🗆 ER/Ou	utpatient	LOth	er _		e 5 🗆 Resider	ice 6 🗆 Othe	r (Specifi	1)
27. Manner of Death 1 Matural	5 Pending	28a. Date of injui (Month, Day	y 28b. 7	Time of injury	28c. Injur work	y at	$\overline{}$	d. Describe hov			/
2 Accident 3 Suicide	Investigation 6 Could not be	20	n. Athana S	anno chiin		Yes 2 No	-				
4 Homicide	determined		ry - At nome, fa	ırın, stree	i, ractory, office		28	 Location (Street) City or Town, 		r or Rura	l Route Number,

Physician/ Medical **Examiner** within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

State

Registrar

9901 Medical Center Drive,

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Roduile, nominal

20850

29c. License number

71323

Registrar's Signa re

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 20 Î Florence Turner 7:45 \mathbf{A}^{M} Elizabeth Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington 11901 Harp Road Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Director 1 🗆 M 2 💢 F 215-14-1688 90 Feb. 10, 1922 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f chomany injury or other traumatic event, the Madical Exercising or other traumatic event, the Madical Exercising Once. 10a. State 10c. City, Town or Location 10d, Inside City Limits Director 1 Tes 2 No MD Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? Funeral 524 George Street 21740 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 1 Yes 2 No Specify: 3 Widowed 4 ☐ Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Kershner Susan Weaver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David McSherry / Son 11901 Harp Road, Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 5/19/2012 Cedar Lawn Mem. Park 4 Donation 5 Other (Specify) Hagerstown, Maryland 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signatur 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ Cholangio Carcinoma disease or condition resulting in death) Y-cars Due to (or as a consequence of) Medical **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-tra that initiated events resulting in death) Last Due to (or as a consequence of) physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the ! use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery Ectopic pregnancy for Month Day Vear Pregnant at time of death Other (specify) 4 ☐ Pregnant 9 ☐ Unknown detached 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown page 2 should neec 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an After this certificate has autopsy Yes 20 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home & Residence 6 Other (Specify) မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1X Natural injury 5 Pending work?
1 Yes 2 No after death Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ct, Haferstown, NO 21740

29c. License number

D0068995

Registrar

within 2

only one

29b. Signature and title of certifie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Thelma Marie Troup Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death **Examiner** Meritus Medical Center Hagerstown Washington Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Social Security Number **Funeral** Hours 214-28-5394 Director 1 ☐ M 2 🛣 F Maryland 101 01/24/1911 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State Examiner must be notified at Director 1 Yes 2X No Maryland Washington Boonsboro 10f. Zin Code 10a. Citizen of What Country? ō 10e. Street and Number 23a Funeral USA 21713 18221 Manor Church Rd items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces?

1 Yes 2 No Black, White, etc. or . ģ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 🗌 Yes 2 🔀 No If Yes, Give Year or Dates Specify: White 3¥ Widowed 4 ☐ Divorced "natural", Completed other traumatic event, the Medical Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Factory Seamstress Be 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) ပ Amos Alexander Mamie Baker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 18221 Manor Church Rd Boonsboro Maryland 21713 Health tem 27 Paul Brown/ Son Baltimore, tem 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot Page 1 1 K Burial 2 Cremation 3 Removal from State Rest Haven Cemetery 05/21/2012 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee 1601 Pennsylvania Avenue Hagerstown MD 21742 hs that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one ca Immediate Cause (Final DISETHE 13X AUSTUATIO Physician/ OBSTRUCTIVE disease or condition resulting in death) ithorica Medical Due to (or as a consequence of): Examiner CAEDIO - PULMONATO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami PNEDMONIA Cause (Disease or injury and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical DIADETES The law requires that the death certificate be MELLINS Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No jo Month Dav Year Pregnant at time of death 5 Other (specify) detached Unknown the s been signed by to should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I Yes 2 1 🗌 Yes 2 🔀 No funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? ဂ 1 Yes 2 🕅 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at work? injury 5 Pending 1 Natural 2 No Accident Investigation by the 1 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21740.

DHMH 17 Rev 06-2011

State

Registrar

81m

31. Date filed (Month, Day, Year)

MUS

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ALTWA

1190

32. Pégistrar's Signature

Mr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 8:09 PM 2012 Daniel Edward Thompson, Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington 103 Willard Street Hagerstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 🛛 M 2 □ F Feb. 1 1932 Hours Mary Land Director 80 217-28-0864 Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1X Yes 2 ☐ No Maryland Washington Hagerstown 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 103 Willard Street 21740 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: If Yes, Give White 3 Divorced 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Self-Employed of Health and Mental Hygie If item 27 is marked other ir other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Daniel E. Thompson, Sr. Nora Hiser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 103 Willard Street, Hagerstown, Maryland 21740 Loretta Thompson - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Haven Cemetery 5/19/2012 Hagerstown, Maryland ature of Funeral Service Licens 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ MYOCARDIAL ROBABLE disease or condition resulting in death) MKRISIS Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of n attending physician and for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year been signed by the a should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? g Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performed? Hospital or Attending Physician: The 24 hours after death. Funeral Director. After this certificate I 2 🗆 No Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 2 Z No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 A Natural 5 Pending work Accident Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier MAY 17,2012

210-4

State Registrar

DHMH 17 Rev 7/2009

2. Projector's Signature

STREET #306 HACKERSTOWN MB 21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Yashvant Patel

MAY 17 2012

31. Date filed (Month, Day, Year)

Maryland 21215-0036

Saltimore,

Box 68760

P.O.

Records,

Division of Vital

,6000 Executive Blvd., Suite 625, Rockville, MD 20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month :21 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Himore +1 If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months (Month, Day, Year) Jan. 16, 1944 Director 241**-**66-6070 1 XM 2 □ F 68 North Carolina ir than "natural", or Items 23a or 28a-f shov the Wedical Evaniner must be notified at 10a. State 10c. City, Town or Location 10b. County Director 10d. Inside City Limits Marvland Montgomery Burtonsville 1 🗆 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4257 Tazwell Terrace 20866 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 X No 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 X Divorced Specify Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, Ite Me Elementary/Secondary (0-12) College (1-4 or 5+) Clergyman Religion Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hoyle Taylor Marylene Bangle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael J. Craig -Friend 4257 Tazwell Terrace Burtonsville, Maryland 20866 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Daniels Lutheran Church Ceth. 5/21/2012 Lincolnton, North Carolina Signature of Funeral Service License Bonald Vie Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) NTERSTITIA Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ne attending physicien and led for use as the burial-transit or Attending Physician: The lew requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day sate has been signed by the a page 2 should be detached it 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform After this certificate 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No <u>|</u>은 1 Inpatient 2 ER/Outpatient 3 DOA nours efter death.

neral Director: After this y filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours ef To the Funeral Di completely filled in Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 800 State 7 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Z Certificate of Death Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>012</u> Month Physician/ Rose Louise Unruh рм 8:20 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 23145 New Cut Road Clarksburg Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours (Month, Day, Year) 578-22-9982 Director 1 □ M 2 🖾 F 87 Jan. 31, 1925 Washington, DC Usual Residence of Decedent 28e-f show th and Merital Hygiene. 27 is marked other then "netural", or items 23a or 28e-f shoi treumetic event, the Medical Evarriner must be nutflied at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Montgomery Clarksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23145 New Cut Road 20871 USA death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. ant: If Item 27 is marked other then "netural", or Completed by Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: White 3 → Widowed 4 □ Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Flementary/Secondary (0-12) College (1-4 or 5+) 12 Secretary Record Distributor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Antonio Catena Ruth Fearson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Unruh/Daughter 23145 New Cut Road, Clarksburg, MD 20871 Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Importent: If it 19 2012 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State May injury o 4 Donation 5 Other (Specify) Fort Lincoln Cemetery Brentwood, MD Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licenses 500 University BLvd. W., Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Coronary Artery Disease Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

The funeral Director: After this certificate has been signed by the attending physician and implemental filled in by the funeral director, page 2 should be detached for use as the burial thransit Atrial Fibrillation that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Tho

9 Unknown Day 5 Other (specify) Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 ♠ N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \boxtimes Residence 6 \square Other (Specify) 1 🗌 Yes 2 🗓 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) NPT May 15, 2012

Registrar

DHMH 17 Rev 06-2011

State

Vinu Ganti, MD 19529 Doctors Drive, Germantown, MD 20874

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

17

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ 16 4:42 May William Gregory Volenick Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Howard Columbia Gilchrist Hospice Care If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months Hours Director 215-28-1766 Yrs 06/09/1931 MD 80 ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 Yes 2 X No Ellicott City MD Howard 10g. Citizen of What Country? 10e. Street and Number ral", or items 23a Examiner must be Funeral United States 21042 2525 Jonathon Road death 12. Was Decedent Ever in U.S. Armed Forces?

1

Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Completed by Maryland 21215-0036 1 ☐ Yes 2X No Specify. 3 ☐ Widowed 4 ☐ Divorced White Year or Dates item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) NSA 4 Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Augusta Hubbard Leo J. Volenick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2525 Jonathon Road Ellicott City, MD 21042 Department of Health a Important: If item 27 is any injury or other traionce. Emma Louise Volenick - Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 05/19/2012 Baltimore, MD 4 Donation 5 Other (Specify) Woodlawn Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Annroximate Interval Between Inset and Death Physician/ VEGIS disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine ardiovaccular Disease as the burial-transit Atherosclerot that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 4 Pregnant Pregnant at time of death 2 No ate has been signed by the a page 2 should be detached g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 1 No 1 Yes certificate 1 Yes 2 No ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 VOther (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Time of 28b. Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No injury 5 Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a **To the Funeral L** Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0060632

Registrar

DHMH 17 Rev 06-2011

State

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ANE

COLUMBIA

6336 CEDAR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Thelma Lorraine Wheeldon May 177 2012 9:45 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Jan. 11, 1932 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Months 214-28-5072 Maryland 80 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director notified Frederick 1 Yes 2 No Maryland Frederick 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or must be r Funeral 21701 6434 Quinn Road United States items death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iter edical Examiner Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: White Specify: Completed 3 Widowed 4 Divorced of Health and Mental Hygiene.
I item 27 is marked other than "natu other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Manager Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ Russell Tobery Claudia Sier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6434 Quinn Rd., Frederick, MD 21701 John Wheeldon / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place)
Resthaven May 16,2012 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) <u>Memorial Gardens</u> permit. 21. Signature of Funeral Service Licenses Resthaven Funeral Services, Skkot Cody P.A. Frederick, MD 2 9501 Catoctin Mountain Hwy. MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition nset and Death Physician. Medical resulting in death) Examiner Cardine Sequentially list conditions if any, leading to immediate cause. Enter Underlying Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Day Month Year Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy performed? Yes 2 No 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) ပ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MO51610 Michael A. TOlino, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Guilford Frederick 0 21704 SI 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAY 1 6 Registrar

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			State Registrar	(and)		Certifica	te of Deat	th		Reg. No. 201	2 1/601
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	Funeral Director		Social Security Number 6		e (In yrs. last bir	thday) If Und Month	er 1 Year If U	nder 24 Hrs.	8. Date of Birth (Month, Day	n 9. l	Birthplace (State or Foreign Country)
			212–50–8332 Usual Residence of Decedent	1 AM 2 LI F	64	Yrs.			Aug. 24	, 1947 Ma	aryland
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	th with ms 23a must I	Funeral	62 Felfoot Driv			140.00	217.			US	
Baltimore, Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 🛣 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates.	ver in U.S.	If Yes, sp	edent of Hispanio ecify Cuban, Me: 2 X No Spe	xican, Puerto F	city Yes or No- Rican, etc.)	14. Race - Ar Black, Wl Specify: V	
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aryl	nould band Me		Timothy E. Will 19a. Informant's Name/Relationship		191	o. Mailing Addre			Summe	City or Town, State,	Zin Code)
Σ,	and 2 st Health a tem 27 is		Wayne D. Wilhid	le/Brother		-				own, Maryl	
nore	age 1 a int of H t: If ite / or ott		20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3	Removal from State	cemete	of Disposition (N ery, crematory o	other place)		ate	20c. Location - City	
altir	permit. Page 1 Department of Important: If i any injury or o		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		Stau	ffer Cr 22. Name	ematory and Address of F				k, Maryland cal Home, P.A.
8	Pel E E		Lyce	J. CM	unew			onal P	ike, Bo	onsboro,Ma	ryland 21713
	Physician/ Medical Examiner		23a. Fart 1. Enter e disease, or co shock, or he if failure. List onl Immediate Cause (Final disease or condition resulting in death)	ly one cause on each line	consequence	2 50	Reros	as cardiac or	respiratory arre	3 51,	Approximate Interval Between Onset and Death
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0	(C) 4-	g	resulting in deathy East	d.	Consequence	Ot).					
Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. The Funeral Injector added the certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live Birth of 1 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal deat	h 3 🗌 Ectopi 5 🗍 Other				23d. Date of Month	delivery Day Year
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Vita	/siciar s certif directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	ant 2 DER/O	utpatient 3 🗆	Other:	Death (Check	,	C	
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Divisi	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		3 Suicide 6 Could no 4 Homicide determine	ed 28e. Place of Injur	. (Specify)				City or Town		
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_	To the Comp		29b. Signature and title of certifier			2	ec. License numb	per	2	29d. Date signed (Mo	nth, Day, Year)
			30. Name and address of person vin	Manafa	agth (Itam 02-1	(Typo Dring)	K093	3556		5/18/12	<u>. </u>
JW	-3		Nancy Man	ahan CRA	P 112	196, FIIII) 26 Op	1 Ct. +	lagers	town.	Md. 21	740
	Sta Registra		31. Date filed (Month, Day, Year)	32 Registra	r's Signature	ban		,	,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. L Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ marie Wiles 05 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washindton Manor Health Case Center Haberstown Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 219-12-0357 Director 86 1 M 2 X F Maryland July 3, 1925 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10b. Count 10c. City, Town or Location Director 1 Yes 2X No Hagerstown Washington Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21742 USA 20526 Trovinger Mill Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 hours after 1 ☐ Yes 2 No Specify: white 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 hand Mental Hygiene. 7 is marked other than "n College (1-4 or 5+) Elementary/Secondary (0-12) retail sales sales clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emma Grace Rummel Harry W. Suter permit. Page 1 and 2 should Department of Health and Me Important: If item 27 is mari 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 5758 Anchor Hills Dr., Sylvania, Ohio 43560 Kenneth M. Wiles - son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State injury or 5/26/12 Hagerstown, Maryland Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) any inj once, Signature of Juneral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 1 Labrille 415 E. Wilson Blvd., Hagerstown, Md. 21740 8/6 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Chronic disease or condition Lidnier Medical resulting in death) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ORONORY Examine Diabetes Mell that the death certificate be executed sician and burial-tran Due to (or as a consequence of resulting in death) Last physician ascular Dementra with Behavioral Distu Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) ____ for in the past 12 months? Day Month Year Pregnant at time of death 1 ☐ Yes 2 🔀 No g ☐ Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Osteoporosis, GERD, Hypothyroidism 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe Hospital or Attending Physician: The this certificate 1 ☐ Yes 2 X No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Hospital ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.

Funeral Director: After this letely filled in by the funeral. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 5/21/2012 R125360 Name and address of person who completed cause of death (Item 23a) (Type, Print) 71W-2 P-333 Mill Street, Haberstown, ND 21740 31. Date filed (Mont State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1157 PM Edna Mae Williams Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hagerstown Meritus Medical Center Washington County Social Security Number Birthplace (State or Foreign Country) 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Funeral (Month, Day, Year) 218-50-4659 92 **Director** 1 □ M 2 🗓 F Oct. 20,1919 Michigan Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at **Funeral Director** Maryland Washington County Hagerstown 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 1104 Glenwood Ave. 21742 U.S.A. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married "natural", or 2 X No Baltimore, Maryland 21215-0036 Yes If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White Completed 3
▼ Widowed 4
□ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) of the and Mental Hygiene.

27 is marked other than "I traumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Personal Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Charles Rambo Edna Cobleigh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heath ar Important; If item 27 is any injury or other trau Dean L. Williams-son 1104 Glenwood Ave. Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Cedar Lawn Mem. Park 5-22-2012 | Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Acure ISCHEWIC disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner Due to for as a consequence of frany, leading to in mediat cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician a for use as the burial-1 Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months Month Dav Year Pregnant at time of death ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? to brillation 1 Yes 2 No 3 Probably 4 Unknown Tabolic 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s performed 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 No 2 Accident s after death Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Funeral D Medical 29a. Certifier 🕮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completely f

JW-6 State

30. Name and address of person who completed cause of death, (Item 23a) (Type, Print) MANCISC 31. Date filed (Mo

2012

29d. Date signed (Month, Day, Year)

MOU

Registrar DHMH 17 Rev 06-2011 (Check

only one)

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

11006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Geraldine Wilkinson May ^D2012 20 Medical 5:52 P 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 203 Clayton Ave. Westernport Allegany Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 12 1930 9. Birthplace (State or Foreign 214-28-6354 Days Director 81 1 M 2 XF Maryland Yrs. Usual Residence of Decedent ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mudical Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Allegany Westernport 1 🗌 Yes 2 😾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 203 Clayton Ave. 21562 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. δ 1 ☐ Yes 2 🗷 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Completed 3 X Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any Injury or other traumatic event, the May Once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Housework unknown Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Wilson Keller Ruth Raines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Devlin/ daughter 19802 Big Lane, Midland, Maryland 21532 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other
Philos Cemetery 05/23/2012 Westernport, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Pervice Licensee 22. Name and Address of Facility Boal Funeral Home 7 man 111 Church St, Westernport, Maryland 21562 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death Drewnang disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-tran resulting in death) Last Due to (or as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months? Pregnant at time of death i after death.
I Director: After this certificate has been signed by the a with the funeral director, page 2 should be detached in hy the funeral director, page 2 should be detached in his the funeral director. Day Yes 2 No Month 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No 2 🗆 No 1 Tes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 🗌 Yes 2 Z No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1_ANatural 5 Pending 2 Accident Investigation 1 ☐ Yes 2 ☐ No ☐ Suicide ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by determined Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or within 24 hours at To the Funeral D Medical 29a Certifier To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier lus D212 46 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Jesus Tan, 4 Broadway, Frostburg, MD 21532

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

MAY 21 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May Day 2012 Year Richard Allen Wilkinson 13 7:30 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 203 Clayton Ave. Westernport Allegany i. Social Security Number 214–62–4651 If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months 59 Hours (Month, Day, Year, Director 1 ፟ M 2 □ F June 10 1952 West Virginia filad within 72 hours aftar death with tha Maryland at Hyglana. at Hyglana. Acher than "natural", or items 23a or 28a-f show went, the Medical Evanting must be notified at went, the Medical Evanting must be notified at 10b. County 10a, State 10c. City, Town or Location Director 10d. Inside City Limits Allegany MD Westernport 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 108 Spring 21562 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 1X Yes 2 No If Yes, Give Vietnam Year or Dates. Completed by Baltimore, Maryland 21215-0036 white 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Town Government maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paga 1 and 2 shouid ba flis nant of Haaith and Mantai ∤ ant: If Item 27 ia marked o John Wilkinson Geraldine Keller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Wilkinson Jr/son 207 Ross St, Westernport, Maryland 21562 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Cumberland Crematory 05/14/2012 parmit. Paga 1 s
Dapartmant of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Cumberland Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Boal Funeral Home 111 Church St., Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) rartinoma SMO Medical Due to (or as a consequence of): ⁷Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exam attanding physician and I for usa as tha buriai-transit Cause (Disease or injury that initiated events resulting in death) Last or Attanding Physician: The law raquires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year baan signad by tha s should ba datachad 9 Unknown 9 Unknown <u>о</u>. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? s certificata has t diractor, paga 2 s 24a. Was an performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: "
within 24 hours after death.

To the Funeral Director: After this certific: completaly filled in by the funeral director, **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 (No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 721488 romad May 14 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Thomas Devlin, 20 Douglas Ave, Lonaconing, MD 21539 31. Date filed (Month, Day, Year) 2. Registrar's Signa State MAY 1 4 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Bettie **Avent** May 28, 2012 3:35a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death **Baltimore Baltimore Future Care-North Point** Social Security Number **Funeral** Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Hours 1 □ M 2 1 F Director 242-14-4384 91 Oct 13, 1920 or 28a-f show rral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No **Baltimore Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21207 U.S.A. 5405 Hutton Avenue Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Force þ Black, White, etc. 1 Never Married 2 Married 1 Yes 2X No should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black "natural", 3 🕅 Widowed 4 🗌 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) School **Teacher Aid** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lauretta Robinson William Robinson other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 5404 Hutton Avenue, Baltimore, MD 21207 John Tatum 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Jun 01, 2012 Windsor Mill, Md. 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Se prentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death n signed by the at 2 No 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 After this certificate has perform 1 Yes 2 No 25. Was case referred to nedical examiner? Be 26. Place of Death __eck only one) Hospital Other: 2 1 No ည 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: /
completely filled in by the Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier D42101 Name and address of person who completed cause of death (Item 23a) (Type, Print) aue Baltinue MD AFROZE MUNCER 401E 1-08+ 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State o	of Maryland		rtment of		and M			12	17607
			Registrar 1. Decedent's Name (First, Middle	Last)		007	- Incate or	Douth		2. Date of Dea	1eg. 140.		3. Time of Death
	Physicia		Samuel Aiken							May 20	2012	Year	9:45 AM M
	Medic Examin		4a. Facility Name (if not institution,	give street and nun	nber)		4b. City, Town,	or Location	of Death		4c. County	of Death	
			Charlestown Re	tirement	Ctr		Catons	ville	:		Balt	timore	e
ī	Funeral Director		5. Social Security Number 219–22–1933	6. Sex 1 X M 2 □ F	7. Age (In yrs. la 83	st birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Birtl (Month, Day June 14	, Year) 1928	9. Birthp Count Mar	place (State or Foreign try) 1and
			Usual Residence of Decedent		40.00	- 1							0d. Inside City Limits
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	e Ma r 28a notifi	Dire	MD Ba1	timore		Cator	sville				10a, Citizen of	What Cour	
	vith th 23ao st be	ral	715 Maiden Ch	oice Lane	#CC120			21228			USA		,
	eath v	Funeral Director	11. Marital Status	12. Was Dece	edent Ever in U.S	i. 13. V	/as Decedent of	Hispanic Or	igin? (Spe	cify Yes or No-		ce - America	
ထ္ထ	fter de , or it amine	by	1 Never Married 2 🛭 Mar	If Ves Giv	2 🗌 No		Yes, specify Cut			nicari, etc./		ck, White, e : whi	
00	urs a tural' al Exa	ted	3 Widowed 4 Divorced	Year or D	re 150-	-52							
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b	be filed within 72 hours after death with the Maryland and that Hygiene 4 sho ked other than "natural", or items 23a or 28a-f sho ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, L	ast)							Maiden Surnam	e)	
Уlа	should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	유	David Aiken	·						enbaum			
Baltimore, Maryland 21215-0036	of Health and Dents of Health and Ments fitem 27 is marked rother traumatic e		19a. Informant's Name/Relationsl Patricia Aike			19b. Mailin 715 M	g Address (Stree [aiden C]	t and Numb hoice	er or Rura Lane	#CC120	; City or Town, S Catons	State, Zip C ville	ode) , MD 21228
ore,	Page 1 and ment of Hes ant: If item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 Removal from			sition (Name of natory or other pl	ace)	1	Date	20c. Location	- City or To	own, State
atim	permit. Page Department of Important: If any injury or once.		4 Donation 5 Other (S 21. Signature Luneral Service I	1	rector	22	Name and Add	ress of Facil	itBoar	d 655 W	. Balti	more	Street
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	nysician/ Medical Examiner		23a. Part 1. Enter the disease, of shock, of heart failure. List of Immediate Cause (Final disease or con), resulting in death)	only one cause on ea	caused the death ach line. (or as a consequ	Pom	er the mode of dy	ring, such as	s cardiac d	or respiratory arr	est,	-	Approximate Interval Between Onset and Death
	ate be executed by sician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or impury that initiated events resulting in death) Last	c	(or as a consequ								
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Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b, Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	tcome of pregna Birth 2 Feta gnant at time of c nown	l death 3	Ectopic pregna Other (specify)	ncy				ate of delive	ery Day Year
P.O.	that the		Part II. Other significant condition	1				_	t I.	23e. Did to	bacco use con	tribute to th	ne cause of death?
S,	v requires that s been signed to should be deti	og p		dy	sphag	ca	aut.	ref	19	1 🗆 '	Yes 2 No	3 🗌 Prob	bably 4 🗆 Unknown
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<u> </u>	Physi this c al dire	은	1 Yes 2 No	1 = 28a. Date	Inpatient 2	ER/Outpatier 28b. Time of	nt 3 🗆 DOA 28c. Inj				dence 6 Oth)
0 0	ding l :h: After funer	cate	1 Natural 5 Pendii 2 Accident Investi	ng (Mor	oth, Day, Year)	injury	wo	ork? □ Yes 2 [Zed. Describe i	low injury occur	eu	
Division of Vital Records,	To the Hospital or Attending Physician: whin 24 hours after death as a feet death or the Funeral Director: After this certific completed filled in by the funeral director,	Certificate:	3 Suicide 6 Could 4 Homicide detern	not be 28e. Place	e of Injury - At ho ling, etc. (Specify	ome, farm, str	eet, factory, office	е		28f. Location (5 City or Tow	Street and Numb vn, State)	per or Rural	l Route Number,
	Hospit 24 hour Funera eted fille	Medical	(Check 2 Medical I	Physician: To the lexaminer: On the ba	sis of examination	n and/or invest	tigation, in my opi	nion, death	occurred a	t the time, date a	ınd place, and dı	ue to the ca	use(s) and manner stated.
_	To the within To the compl	Σ	only one) 3 LJ Certifying 29b. Signature and title of certifie	6	E war								
			30. Name and address of person	who completed cau		1 23a) (Tyne, F	29c. Licer	CC =	1				The Con-
			Joan	2 Afr	7//	Mas	Ren	Che	ue	(an	(A	Kon	46 H
	Sta Registr		31. Date filed (Month, Day, Year)	112	Registrar's Signa	park							2/2,5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18 Per FH G928 6/12/2012 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2012 Year Month Physician/ 3 7:30 P M June David James Adam Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Montgomery Hospice Casey House 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth Funeral Days March 4, 1938 1 X M 2 🗆 F California 554-48-9178 74 **Director** Usual Residence of Decedent or 28a-f show notified at 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County with the Maryland Director 1 ☐ Yes 2X No North Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? P er than "natural", or items 23a on the Medical Examiner must be Funeral United States 20852 5809 Nicholson Lane, #1102 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 X Yes 2 □ No Black, White, etc. 1956-1 Never Married 2 X Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: If Yes, Give 1962 3 Widowed 4 Divorced White Completed Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. The Many injury or other traumatic event. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Mechanical Engineer Federal Government Be 17. Father's Name (First, Middle, Last) 18 Pyptzabeths Burnsacourtney Easton ပ္ Elizabeth Easton David Adam 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5809 Nicholson Lane, #1102, N. Bethesda, MD 20852 Monica Adam / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 4, 1 Burial 2 X Cremation 3 Removal from State June Montgomery Crematorium, Inc. 2012 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Acensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01305 Approximate Interval Between Onset and Death 23a. Part 1, Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Metastatic Mesothelioma Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of: burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a d for use as the burial-Physician/Medical certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Partial Small Bowel Obstruction 1 Yes 2 No 3 Probably 4 Winknown Division of Vital Records, been si should l 24b. Were autopsy findings available 24a. Was an Hospital or Attending Physician: The law I prior to completion of cause of death? page 2 s certificate has performed? Yes 2 No 1 🗌 Yes 2 No Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 ICOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: injury X Natural 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 4, 2012 D60634

DHMH 17 Rev 7/2009

State Registrar 6001 Muncaster Mill Road, Rockville, Maryland 20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bindu Joseph, MD 31. Date filed (Month, Day, Year) JUN 0 5 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month June William Paul Adamo, Sr. 12:30 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harford Forest Hill Senator Bob Hooper House Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Hours Min. (Month, Day, Year) 88 216-16-1317 **Director** 1X M 2 □ F 924 Maryland January 10, Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Kingsville Maryland Baltimore 1 - Yes 2 - No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16 Vista View Court 21087 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify. Completed 3 x Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore City Police Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Unknown Joseph Adamo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
16 Vista View Court Kingsville MD 21087 19a. Informant's Name/Relationship (Type, Print) William P. Adamo, Jr. /son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 🗋 Donation 5 🗋 Other (Specify) 6/7/12 Woodlawn MD Lorraine Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, 5305 Harford Road Inc. Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 6LUN Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran. that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical W/LL/AM ADAMDivision of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other Specific HOUSE 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending injury Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🔲 Homicide City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and 29c. License number 29d. Date signled (Month, Day, Year) 1901 ess of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month O L O 2 10.03 M 2012 Jean Marie Bradley Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Harford Harford Memorial Hospital Havre de Grace If Under 1 Year If Under 24 Hrs. 8. Date of Birth OCt. 19, 9. Birthplace (State or Foreign Country) Maryland . Social Security Number 7. Age (In yrs. last birthday) **Funeral** Ye 1929 1 □ M 2X F Director 218-26-4583 82 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2🏋 No Abingdon Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21009 USA 628 Riverview Road "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black. White, etc. 1 Yes 2 XNo ģ 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 ☐ Yes 2 XNo Specify: Completed 3 ₩ Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 7 in and Mental Hygiene.

7 is marked other than marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Marie Dillman Charles Elsworth Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a 628 Riverview Road, Abingdon, Maryland 21009 Caroline Shea / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State any injury or 1 X Barial 2 ☐ Cremation 3 ☐ Remova Parkwood Cemetery 6/5/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Sig a re of Funera 22. Name and Address of Facility vir e License McComas Funeral Home, P.A. Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final -Physician/ HOUR disease or condition Medical resulting in death) Examiner CARDIOVASCULAR SC 0 Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami sician and burial-trans Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical 09289 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Records, P.O. cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was ... autopsy performed? certificate 2 🗆 No 1 Yes **Division of Vital** 25. Was case referred to medical or Attending Physician; Be B 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA ဂ္ within 24 hours after death.

To the Funeral Director: After this funeral 28a. Date of injury 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, 5 Pending М 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) MEMOIVAL UNION eath (Item 23a) (1900) URANGNIMD GOPALA RAO

State

Registrar

31. Date filed (Month, Day,

Year,

JUN 0 5

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 23a-d, pt.11, per me, g928 6-25-12 sm State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. Z Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 2012 DARAH OCKRIL 06 LEVINS 205 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Min. Hours **Director** 430-38-2088 1 M 2 1 F 87 19, 1924 Sep. Arkansas Usual Residence of Decedent at 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 224 Hunters Run Terrace 21015 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ò 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Yes Yes, Give 2 **X**No Baltimore, Maryland 21215-0036 1 Yes 2 KNo Specify. "natural", Specify: Completed 3 X Widowed 4 Divorced White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) ed other than 'event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) the Federal Government Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ent of Health and Mental H ht: If item 27 is marked ot y or other traumatic even မ James Thaddeaus Cockrill Sara Irene Haden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Feeks / Daughter 130 Cardamon Drive, Edgewater, Maryland 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Department of Important: If any injury or 6/6/2012 Bel Air Memorial Gdn. 4 Donation 5 Other (Specify) Bel Air, Maryland . Signature of Funer Service License 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 23a. Part 1. Enter the disease, or complications that consequences and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on the line. Intracranial Hemorrhage Approximate Interval Between Onset and Death Immediate Cause (Final PRATOR Physician/ disease or condition resulting in death) Medical Due to (or as consequence of): Fa11 **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) EFFICATION APPROVED BY MEDICAL CLAMIN Exami burial-trar Due to (or as a consequence of) resulting in death) Last ed by the attending physician detached for use as the burla Division of Vital Records, P.O. Box 68760 $^{\prime} au$ Physician/Medical ARS IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aspiration, Pneumonia ate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? FRACTURES R Completed by 1 Yes 2 No 3 Probably 4 Unknown ELBOW 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Dementia has autopsy performed After this certificate Yes Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certifica 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify Hospital: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred ATED I NNER 28c. Injury at work?
1 Yes injury 1 Natural 5 Pending MAY 252012 UNWITNESSED FALL 2. No 6 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Somerford 2717 RIVA RD, ANNAPOLL M Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MO 0/20/2 vicha 40 Name and address of person who completed cause of death (Item 23a) (Type, Print QNNAPOLISMO LIYO, NCHREL 31. Date filed (Month, Day, Year, State 32. Registrar's aignature JUN 0 5 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ une Medical City, Town, or Location of Death 4a. Facility Name (if not institution 4c. County of Death **Examiner** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days ☐ M 2 🗓 F Hours Director 4/06/2012 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🖵 Yes 2 🗌 No Raltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Diener Place Apt. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☐ Yes 2 X No Black, White, etc þ 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify. AA Completed 3 Widowed 4 Divorced Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) NΑ NA NA NA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Gerald Baker <u> Latia Robertson</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Balto., Md. 2122 20c. Location - City or Town, State Apt. 204 <u> Latia Robertson - Mother</u> <u> 204 Diener Place</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 XX remation 3 Removal from State 4 Donation 5 Other (Specify) 6/7/2012 Catonsville, Md. Metro Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Homes, P.A. any in Md. 21217 St. Baltimore, 638 N. Gilmor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death Linknown been signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has autopsy performed' death? 1 Yes 2 No 1 🗌 Yes 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Hospital ၉ 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) Data of injury (Month, Day, Year) Manner of Drath Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural 5 Pending 1 Yes 2 \square No Accident Investigation within 24 hours after death To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier ath (Item 23a) (Type, Print) erson who completed cause of de 7 Ba Himone, MO maag 32. Registrar Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of M	aryland	d / Depar	tment of	Health and	d Mental H	ygiene		
			1 - State Registrar		Certi	ificate of	f Death		Reg. No.2	012	17613
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1	Medi Examir		Carl Clifton Brown 4a. Facility Name (if not institution, give street and number)			4b. City, Town	or Location of De			2012_ nty of Death	2231
			St. Agnes Hospital			Bal	timore			ny or Boath	
1	Funeral	Г		e (In yrs. las		If Under 1 Year Months Day			lirth Day Yearl	9. Birth	place (State or Foreign
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	ind show at	5	10a. State 10b. County	10c. City,	Town or Loca	tion			7 - 0 1 0		0d. Inside City Limits
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<u>8</u>	ld be Menta arked	ျ	Willis Brown				Mary	Bullock			
Jac	shou and is m		19a. Informant's Name/Relationship (Type, Print)		19b. Mailing	Address (Stree	et and Number or i	Rural Route Numb	er, City or Town	, State, Zip C	Code)
2	ind 2 lealth im 27 her tr		Josephine Brown				d Rd. Ba	lto., Md	. 21207	·	
0.00	ge 1 a		20a. Method of Disposition 1 ☑ Surial 2 ☐ Cremation 3 ☐ Removal from State		ice of Disposit metery, cremat		lace)	Date	20c. Locatio	n - City or To	wn, State
Baltimore. Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Deparmit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (Specify)	_ King	g Memor			9/2012	Windso	r Mill	L, MD.
Ba	permit. Pag Department Important: any injury o		21. Signiture of Funeral Service Licensee	_			ress of Facility	ъ.	638 N. G	ilmor	St.
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$\overline{\omega}$	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director, After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 Certifying Physician: To the best of a	ny knowled	lge, death occ	urred at the tir	me, date and place	e, and due to the o	cause(s) and ma	nner as state	d.
	the Hi nin 24 the Fu	Med	(Check 2 Medical Examiner: On the basis of exonly one) 3 Certifying Nurse Practitioner: To the	amination a best of my	nd/or investiga knowledge, de	tion, in my opir ath occurred a	nion, death occurre t the time, date and	d at the time, date place, and due to	and place, and o the cause(s) and	lue to the cau I manner as st	se(s) and manner stated. tated.
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			Now duna	MI		1 12	2549	9	June	03 2	2012
	5		30. Name and address of person who completed cause of de Ani Nadipelli 900		3a) (Type, Print aton /		Baltim	iose r	TD 2	(1229	
	Stat Registra	-	31. Date filed (Month, Day, Year) 32. Registrar	r's Signatur	е					·	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Steven L. Bates State of Maryland / Department of Health and Mental Hygiene 2012 17614 1- For State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Medical Examiner Steven Bates 1220 hrs May 25, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2941 Westwood Ave Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director Months Davs Hours 220-64-8248 59 1X M 2 F Country) MD Yrs 06-11-52 Usual Residence of Decedent any 10b. County 10c. City, Town or Location 10d. Inside City Limits MD NA 1XX Yes 2 No or items 23a or 28a-f shov Baltimore notified at once. hours after death with the Maryland Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2941 Westwood Avenue 21216 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces 1 X Never Married 2 Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. African 3 Widowed If Yes, Give Year permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", injury or other traumatic event, the Medical Framina-Divorced 1 Yes XX No specify: specify: American ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12th Grade NA Liberty Security Security Guard 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Temple Be Lavanule Bates Leola 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2941 Westwood Avenue Baltimore, Maryland 2171
Date 20c. Location - City or Town, State Melvin Bates-Brother Maryland 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Burial 2 X Cremation 3 Removal from State crematory or other place) Metro Crematory 06-02-12 Catonsville, MD Donation 5 Other Specify: Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. Gilmor Street Baltimore. Maryland 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line. Between Onset and /Medical a. Complications of Renal Disease Death Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Physician/Medica; Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and UNPENDED signed by the attending physician be detached for use as the burial AMENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Month Year Day past 12 months? Pregnant at time of Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy performed? death? certificate h Yes 2 V No 2 No 1 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other4 Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 1 🗸 Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 V Natural I Director: 5 Pending 1 Yes 2 No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physicia To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. g (Check only within 2 2 Medical Examine On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) MXI O.C.M.E. June 1, 2012 ddress of person who completed cause of death (Item 23a) **OCME** Mary G Ripple MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001 OCMF 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death BECK Physician/ Year 3:00AM (INF 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CARROLL SYKESVILLE HEALTH Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F 38 883 213 8 COUNTRY) MANY Director Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at Funeral Director KESVILLE 1 Tes 2 X No 10e. Street and Numbe 10g. Citizen of What Country? , or items 23a 115/4 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: WHITE 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h th and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) SALTIMONE PRINTER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FAIRFIELD LANE SYKESUILLE MO 21784 1 and 2 s of Health a item 27 i MARIANNE A. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Durial 2 Cremation 3 Removal from State SOUTH CARROLL CREM 6/4/2012 WINFIELD, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility, W. Zum Isw

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23a. Van V Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 22. Name and Address of Facility \ NZUMBWN I=H & MON CO SYKESVILLE RU ELDERSBURG-MU 21784 Approximate Interval Between shock, or heart failure. List only one cause on each ling Immediate Cause (Final disease or condition resulting in death) weet and Death Physician/ POVS Medical Due to (or as a consequence of) Examiner Whonsonis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Month Year P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 🗌 Yes 2 🗌 No **Division of Vital** funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 No Certificate: To 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After I completed filled in by the funeral 1 Natural 5 Pending 1 Tyes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stone 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 's Name (First, Middle, Last) 2. Date of Death Physician/ une Medical 4a. Facility Name (if not institution, give street artinumber) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TIMDAN COURT ELNERS BURG CARROLL If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Director 1 **X** M 2 □ F DEC 22 1957 MARYLAND 28a-f show 10a. State 10b. Count 10c. City, Town or Location must be notified at **Funeral Director** 10d. Inside City Limits CARROLL ELOERSBURG 1 X Yes 2 No 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a TIMOAN 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force ō þ Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗡 No Specify: "natural", 3 Widowed 4 Divorced Completed Specify: Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) KUCK URIVER MTLANEY other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည SICHARO BRIGHT SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 COLUMBIA 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H
Important: If ite
any injury or ot
once. Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State cemetery, crematory or other place) 19/2012 4 Donation 5 Other (Specify) MARRIOTISVILLE, MD ESTLAWN MEM GAR 21. Signature of Funeral Service Licenses 22. Name and Address of Facility JNZUMBRUNFH8 MONCO. 6028 SYKESVILLERD ELDERSBURGARD 21784 23a. a .V. Enter the dis +s +, or cor shock, or heart failur ... ist only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 as the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No ģ Month Day Year 9 Unknown Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No page 2 Division of Vital To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ▶ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred Natural Accider 5 Pending iniury Accident Investigation Suicide Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined Hospital 4 To the Hospital within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier \mathcal{O}_{i} State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 24 3:43 pM William Bauer Jr May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Baltimore Greater Baltimore Medical Cente Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days **Director** 142-16-3292 1 □ M 2 **X** F 91 Sept 16, 1920 New Jersey 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f MD Baltimore 1 ☐ Yes 2 😾 No Sparks Barer, Willian ö 10e. Street and Numbe 10f. Zip Code items 23a or ner must be r 10g. Citizen of What Country? Funeral 21 Rainflower Path #103 21152 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⚠ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify "natural" Completed 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) the permit. Page 1 and 2 should be filed wit. Department of Health and Mental Hygier Important: If item 27 is marked other thany injury or other traumatic event, the once. executive insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William Bauer Lillian Vollweiler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, S 21 Rainflower Path #103 Sparks, MD Mary Bauer/spouse 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔲 Burial 2 🗌 Cremation 3 🗎 Removal from State 4 X Donation 5 Other (Specify) . Signatur 🔊 Kuneral Service Ronald State Anatomy board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock or heart failure. List only one cause on each line Immediate use (Final disease or condition resulting in death) Onset and Death Physician/ Cardiany Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Pregnant at time of death Day Year ed by the ar 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has performed 2 1 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) eral Director: After thi filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending ☐ Accident ☐ Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar
DHMH 17 Rev 06-2011

CUNTUR

Date filed (Month, Day Year)
JUN 0 5 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

00051347

MD 6701 N charles St Torson MD 21204

Please Type or Print in Black Indeline Ink. Ensure All Copies Are Legible.

ames Daniel B	elto	rd "State 1- For State Registrar	e of Maryland		artment of <i>rtificate of</i>		and	Menta	ıl Hyg		Reg. No.	201	2	1761	
Physici Pedical Exam		James	Dan	iel		Bel			ı	Date of De Month May 29, 2	Day 2012	Year	16	e of Death 00 hrs	
		4a. Facility Name (if not institution, 1330 Laurens Street #2	02			b. City, To Baltimo	ore					County of Deat			
Funeral Director		4855 216-90- 4885 1	Sex 7. A	48 (In yrs. 1	last birthday) Yrs.	If Under Months		If Under 2 Hours	2.00	3. Date of B	,	D/YYYY) 9. Bir Forei			
OW ADY		Usual Residence of Decedent 10a, State 10b, County		10c. City	Town or Location								1	rside City Limits Yes 2 No	
th the Maryland 23a or 28a-f show notified at once.	Director	MD NA 10e. Street and Number	't woot		Daici	10f. Zip C	ode 212	17			•	en of What Cou			
r death wi or items must be	Funeral	1313 Lavrens S 11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorce	12. Was Decede		If Ye	Decedent	of Hispa Cuban, N	nic Origin		ecify Yes or No- 1 Rican, etc.)		Race - American Indian, Black, White, etc. African Decify: American			
36 in 72 hours afte han "natural", dical Examiner	pleted by	15. Decedent's Education (Specify Elementary/Secondary (0-12)	or Dates:		16a, Decedent	24	ccupation	(Give kin			16b. Ki	nd of Business/	of Business/Industry e Improvement		
e, MD 21215-0036 1 and 2 should be filed within 72 Health and Merral Hygiere, item 27 is marked other than item 27 is marked other than r traumatic event, the Medical	Be Comple	12th grade 17. Father's Name (First, Middle, La John E. Belfor	ed Jr.	-			18 J	oan	Jac.	kson	Maiden Surname)				
MD 21 nd 2 should I alth and Mer m 27 is man	To	19a. Informant's Name/Relationship Edward Belford 20a. Method of Disposition			5049	Bige	yе	Ct.,	Wa.	ldori	E, M	or Town, State d 2060 ocation - City or	3		
Baltimore, MD permit. Pages I and 2 sh Department of Health and Important: If item 27 is injury or other traumat		1 X Burial 2 Cremation 4 Donation 5 Other Spec	ify:	State	Place of Disposit crematory or other butus	er place) Memo	ria	1 6	/9/	ate 2012		butus,	,		
Balt Permit Depart Import		21. Signature of Funeral Service Lic	B. Keta	ad the death	43		aba	sh A	ve,			re, Mo	-	.215	
/Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, hoding to live documents of the course (Disease or injury that initiated events resulting in death) Last a. Complications of Paraplegia Due to (or as a consequence of): b. Remote Spinal Cord Injury Due to (or as a consequence of): Due to (or as a consequence of):												een Onset and Death	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Medical	UNPENDED AMENDED										Year			
, P.O. E ires that the signed by the bedetached	ρ	Part II. Other significant condition	s contributing to dea	ath but not re	esulting in the ur	nderlying ca	ause give	en in Part I				se contribute to			
Division of Vital Records, safer Attending Physician: The law requirers at lorect death. All birectors. After this certificate has been sited in by the funeral director, page 2 should b	Completed									1 Yes			ompleti	ndings available on of cause of	
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Divisior To the Hospital or Attend within 24 hours after death To the Foneral Director:	4 Homicide determined (Specify) Local Street 900 West Baltimore Street, B 4 Homicide determined (Specify) Local Street 900 West Baltimore Street, B 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signe									manner as state	ed.				
	Me	29b. Signature and title of certifier	and manner states	el	~		icense n					ate signed (Mo.	nth, Day	,Year)	
3 m	tate	30. Name and address of person when Patricia Aronica-Pollak M 31. Date filed (Month, Day, Year)	ID. Assistant	Medical I	Examiner 9	900 W. E	Baltimo	re Stree	et, Balt	imore, M	ID 2122	3			
Regis		JUN 0 5 2012	Mary 1	2. 6	arker										

		1 _ State	State of Mary		partment of F <i>ertificate of l</i>		lentai Hyg	Reg. No. 20	112	17619
	7	Registrar 1. Decedent's Name (First, Middle, Last)			er imodic or i		2. Date of Dea	ıth		3. Time of Death
Physicia /Medic		ROBERT		= 7			Month	26 3	Year	4.00 PM
Examin	er	4a. Facility Name (If not institution, give si FUTGRE CARE	reet and number)		4b. City, Town, or	Location of Death		4c. County	of Death	
Funeral	all de	5. Social Security Number 6. Sex	7. Age (In	yrs. last birthd	ay) If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl (Month, Day			place (State or Foreign
Director		219-10-9046	M 2 🗆 F	88 Yrs	Months Days	Hours Min.	July 3,			ington DC
and w		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or	Location					10d. Inside City Limits
Maryl a-f sho	tor	MD	I	Baltimo	re					1 √ Yes 2 No
th the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of		ntry?
s 23a	erall	3245 Normount Ave				1216	16.34	USA		
fter de	Funeral	11. Marital Status 1. Never Married 2 X Married 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	2. Was Decedent Ever Armed Forces? 1 ☑ Yes 2 ☐ No	in U.S.	 Was Decedent of H If Yes, specify Cuba 		ecity Yes of No- Rican, etc.)	14. Had Bla	ck, White,	can Indian, etc.
ral", o	ρ	3 ☐ Widowed 4 ☐ Divorced	1 Myes 2 No If Yes, Give Year or Dates: 143	3-46	1 □Yes 2 X No	Specify:		Specif	y: b1	lack
"natu	Completed	15. Decedent's Educa (Specify only highest grade	ation	16a. De	cedent's Usual Occup ive kind of work done o e. DO NOT use retired	ation during most of worki	ng	16b. Kind of B	usiness/In	dustry
within iene. than	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)		e. DO NOT use retired chinest	1)		engrav	ing δ	printing
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Maritral Examiner must be reutified at	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name			ne)	
Ment Ment arked	2	Joseph Brinkley				Joseph	ine Gra	y 		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Examiner is ust be rediffed at once.		19a. Informant's Name/Relationship (<i>Typ</i> Bernetta Brinkley,			ailing Address <i>(Street :</i> 45 Normount				, State, Zij 2121	
ss 1 al of Hea f Item		20a. Method of Disposition	20	Ob. Place of Di cemetery, o	sposition (Name of crematory or other place	re)	Date	20c. Location	- City or To	own, State
ment of tant: If Its jury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☑ Donation 5 ☐ Other (Specify)	moval from State			į				
permit Depar Impor any in		21. Signature of Funeral Service Licenses Ronald S. W	de, Virect	or	22. Name and Addres			. Balti	more	Street
		3a. Part 1. Inter the disease, or complice shock, if heart failure. List only one	ations that caused the	death. Do not	Baltimore, enter the mode of dyin	M1) 212(ng, such as cardiac) I or respiratory ar	rest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	oddoo on odon iino.	DEME	WILA					Onset and Death
Medical Examiner		resulting in death)	Due to (or as a cor	sequence of):	, ,57					Ma (Hart) and
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a cor	-	<i>C1, 1</i>					MENERM
cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	CEREBI	RO VAS	cuisa,	ACKDEN	~		Ju	MICHONA
be executed sician and burial-transit		resulting in death) Last	Due to (or as a cor							
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eath certifi attending p for use as		IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pr 1 ☐ Live birth 2 ☐		2			23d. Da	ate of deliv	ery/ery
or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	4 ☐ Pregnant at time 9 ☐ Unknown		3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	y 		M	onth	Day Year
res that the signed by be detact		Part II. Other significant conditions cont	ributing to death but not	t resulting in th	e underlying cause give	en in Part I.	23e. Did to	bacco use con	tribute to 1	the cause of death?
quires en sigr uld be	ed by	END STAGE 1	ZENAL DI	SEASE			1 □ Y	′es 2 □ No	3☐ Pro	bably 4 Unknown
law requir as been s 2 should	Completed	PERIPHERAL V	AS CULAR	OTHE	ASE		24a. Was a	an 24b.	Were auto	opsy findings available ompletion of cause of
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sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	espital:		tiant 3 DOA Othe	26. Place of Deatl				
Physer this eral dir	٦: <u>۲</u>	1 Yes 2 No	28a. Date of Injury	28b. Tim	e of 28c. Injur	4 Mursing no	me 5 Resid			fy)
tending Fleath. tor: After the funer.	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Yea	ar) Inju		<br Yes 2 □ No				
or Atter ter de irecto	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (Sp		street, factory, office		28f. Location (S City or Tow		ber or Run	ral Route Number,
pital o		29a. Certifier Certifying Physi	cian: To the best of my	knowledge d	eath occurred at the tir	mo, data and place	and due to the	cause(s) and m	nannar ac	etated
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur	Medical		er: On the basis of exa and manner stated.							
To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Licens			29d. Date signe		
		A A	TRENDUNG		0003	56948		MAY	2+	2012
		30-Name and address of person who con SAM TAMS (NO A 31. Date filed (Month, Day, Year) 2012	npleted cause of death	(Item 23a) (Typ	oe, Print) O AVE #1	SY BALI	IMME	no 2	124	7
Stat	te	31. Date filed (Month, Day Year) 2012	2. Registrar's S	Signature	arked					
Registra	ir	JUN U O EUIE	Mary .	1. 4.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 16b per 1h g928 6-5-12 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death ecedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OWY 1430 Medical ne (if not institution, give street and number) or Location of Death 4c. County of Death Examiner City, Town 6. Sex If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min (Month, Day, Year) Country) Director 1 № M 2 🗆 F or than "neture!", or items 23a or 28e-f show 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Brand wine 1 Yes 2 No 0f. Zip Code and Numb 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than oary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other treumatic event, Item ter ainer Music Be Maryland 17 Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surna မ 1000 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Yown, State, Zip Code) MD 71*0*W1 Himore Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Jown, State 1 Burial 2 Cremation 3 Removal from State aldorf Trinity 1.12 Mem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice se PEEMAN MIS 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Min History CIPSHIN Medical Due to (or de a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to lor as a consuluence of burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed to the results of the and Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use es the buria Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Yes 2 No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performe 1 Yes 2 No Yes 2 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) B examiner? 100 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 AInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 800 31. Date filed (Month, Day, Year) 32. Re State JUN 05 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician/ Month 2:30 A^{M} 2012 Medical Mary Louise Brickner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Columbia, Mu Gilchrist Hospice Care Howard Birthplace (State or Foreign Country) Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 6/27/1934 178-26-5098 77 **Director** 1 □ M 2**X**XF PA Usual Residence of Decedent or 28a-f show notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director MD Howard Laurel 1

Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò must be n Funeral 8321 Cherrybrooke Court 20723 USA items? death ' 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status the Medical Examiner Armed Forces?

1 Yes 2 No ŏ 1 Never Married Married ð Baltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2X☐ No Specify: If Yes, Give Year or Dates Specify: White "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Educator Elementary School Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) P William Paul Dissen Kathryn Reilly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 st nt of Health a :: If item 27 is Kenneth G. Brickner 8321 Cherrybrook Ct Laurel MD 20723 other! 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Calvary Cemetery 6/8/2012 Pittsburgh, PA Donation 5 Other (Specify) 21. Signature of Funtral Service Licenses 22. Name and Address of Facility Harman Funeral Service PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 7221 Grayburn Dr Ste G GlenB@rnicaMDD2106 Approximate Interval Between Onset and Death Immediate Cause (Final COMPLICATIONS OF CORUMON BUE DUCT CANCER Ph, i ian SEPTEMBER_2011 disease or condition Medical resulting in death) Examiner Esquertially liet exhibitions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day Month 5 Other (specify) the the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by CHRONIC UMPHOCYTIC LEUKEMIA 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s certificate • Hospital or Attending Physician: 24 hours after death.
• Funeral Director: After this certificietely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 A Other (Specify) 2 No HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation
6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Funer completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 [29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie JUNE 4, 2012 D64395 6336 CEDAR LANE COLUMBIA, MD 21044 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEUE DOBERMAN, MD

State

Registrar

32. Registrar's Signature

JUN 0 5 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 4:35 AM Baumann 2012 1) lana Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2 POMONA EAST, #508 BALTIMORE BALTIMORE Social Security Number Year If Under 24 Hrs Days Hours Min. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 👿 Months 1270471923 NY 216-16-0663 88 **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director MD BALTIMORE BALTIMORE 1 ☐ Yes 2 🛛 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? and Mental Hygiene. 'Is marked other than "natural", or items 23a or ranmatic event, the Medical Examiner must be 1 Funeral 2 POMONA EAST, #508 21208 USA filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married 2**X** No Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: WHITE If Yes, Give Year or Dates 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) LIBRARIAN HIGH SCHOOL Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) e 1 and 2 should be fi of Health and Mental If item 27 is marked r other traumatic ev 2 **FORMAN** ANNA EISENSTADT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANNA BAUMANN/DAUGHTER 2406 HUNT DRIVE, BALTIMORE, MD 21209 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BALTIMORE HEBREW REISTERSTOWN, MD 06/03/2012 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service License 8900 REISTERSTOWN ROAD, PIKESVILLE, MD sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Cardio Pulmonary Medical resulting in death) Due to (or as a consequence of) Examiner Ian Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Exami that initiated events resulting in death) Last and the burial-trai Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death signed by the at d be detached for 9 Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the superstance of the control of the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 \square Nursing Home 5 Residence 6 \square Other (Specify, _2 🖳 No Hospital: 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 🔲 Yes Certificate: 28d. Describe how injury occurred 5 Pending iniury 1 Natural 2 🗌 No Accident Investigation completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

DHMH 17 Rev 7/2009

State Registrar

3 [

Yaniv Berger 31. Date filed (Month, Day, Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

only one)

32. Registrar's Signature

29c. License number

700 Quarry Lake Drive Baltimore, MD 21209

H68214

29d. Date signed (Month, Day, Year)

June 1, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2012 May 1:00pm J. Bardeen Margaret Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Baltimore Timonium Lorien Mays Chapel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗶 F Months Hours 90 MD Director 216-12-8007 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits 10b County 10a. State 10c. City. Town or Location Director 1 ☐ Yes 2X No Reisterstown MD Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21136 111 Chartley Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married ğ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates Specify: White "natural" 3 X Widowed 4 □ Divorced Completed traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) other than College (1-4 or 5+) Elementary/Seconday (0-12) Glyndon Elementary Cafeteria Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ည Gaines Gladys J. Albert Shepperd permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10922 Gateview Road Cockysville, MD 21030 Susan E. Grill (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Wesley Chapel Cem. 6-4-2012 Monkton, MD 4 Donation 5 Other (Specify) re of Fune al Service Licensee ELINE FUNERAL HOME 22. Name and Address of Facility MD 21136 11824 Reisterstown Rd. Reisterstown, J. Wayne Osterling 22d. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. erval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): executed physician and the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical law requires that the death certificate be Division of Vital Records, P.O. Box 68760 igned by the attending p be detached for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year Pregnant at time of death 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed? Hospital or Attending Physician: The 2 NO this certificate 1 Tyes 2 Yes After this certifical funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ည 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Watural 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 1 Yes 2 🗆 No ☐ Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 5/3/12012 R079544

State Registrar 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

			For State Registrar		_	-			d / Dep		nt of H	lealth	and N	Mental Hy		้ว ก	12	17624
			Decedent's Nam	e (First, Middle	e, Last)						0 01 .			2. Date of D	eath			3. Time of Death
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	To the Hospital or Attention within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier (Check only	1 Certifyin	ng Physic	cian: To the	e best of	f my know	wledge, de	ith occurred	at the tir	ne, date	and place	, and due to th	e cause(s	s) and m	anner as	stated. to the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 0.5^{Month} Physician/ 201°2 31 7:15 JOHN IVAL BASS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 208 Harlem Rd Arundel Pasadena Anne 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral Min. (Month, Day, Year) 232 32 4312 **Director** 1 **X** M 2 □ F 84 10 1928 West Virginia Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at **Funeral Director** 1 Yes 2 No Anne Arundel MD Pasadena 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 23a 208 Harlem Rd 21122 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? the Medical Examiner Black, White, etc. ò ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: "natural", 3 X Widowed 4 ☐ Divorced Completed 1952 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working than life. DO NOT use retired) ygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Dispatcher Preston Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o ဂ Department of Health and Ment Important: If item 27 is marke any injury or other traumatic Jerry Bass Margaret Austin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Bass, 208 MDJr. - Son Harlem Rd Pasadena, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1. Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Glen Haven Mem Pk 6/4/2012 Glen Burnie, MD 22. Name and Address of Facility GJ Gonce Funeral Home, 21. Signature of Funeral Service Licensee 169 Riviera Drive Pasadena, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last attending physician Physician/Medical P.O. Box 68760 s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
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4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mountain Rd. Pasaders, mp 21122

Registrar DHMH 17 Rev 06-2011

State

Christopher

3708

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State Registrar 30. Name and address of person

JUN 0 5 2012

Year,

31. Date filed (Month, Day,

EAST MELROSE AVEZ

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death James Edward Cook May 31, 2012 Pay Physician/ 4:45 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A 518 West 27th Street Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Dav. 7. Age (In vrs. last birthday) g. Birthplace (State or Foreign **Funeral** 216-42-3264 1 XXM 2 □ F 66 **Director** MD Aug 13, 1945 Usual Residence of Decede 28a-f show 10a. State 10b. County 10c. City, Town or Location at 10d. Inside City Limits Director notified MD N/A 1 XXYes 2 No **Baltimore** 10e. Street and Number ms 23a or must be n 5 10f, Zip Code 10g. Citizen of What Country? Funeral 518 West 27th Street 21211 U.S.A. items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 0 ģ 1 Never Married 2 XXMarried 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates. within 72 hours after Maryland 21215-0036 nan "natural", Medical Exan 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than Elementary/Secondary (0-12) life. DO NOT use retired) College (1-4 or 5+) the Mechanic Automotive event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be 1. Department of Health and Mental. Important: If item 27 is meriany injury or other-1. ပ Wilson Cook Mary Lima 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Cook (Wife) 518 West 27th Street Balto, MD 21211 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 XXCremation 3 Removal from State Atlantic Crematory 6/3/12 Glen Burnie, MD 4 Donation 5 Other (Specify) Signature of Funeral Service 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home. Inc. 3631 Falls Road Balto, MD 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. nterval Between Inset and Death Immediate Cause (Final 15c Phymiciany ocalo 9 Hours disease or condition Medical resulting in death) Due to or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami the burial-transi Due to (or as a consequence of): attending physician Physician/Medical certificate be P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the a should be detached t g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Division of Vital Records, 2 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? OCOMAC 24a. Was an autopsy perform has To the Hospital or Attending Physician; The within 24 hours after death.

To the Funeral Director: After this certificate It. Yes 2 funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 🗌 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 only one) Certifying Nurse Practitioner: To the best of my knowledge, death occur red at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

State Registrar

DHMH 17 Rev 06-2011

30. Name and address of

O NUL

5

30 Falls Kd

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

29d. Date signed (Month, Day, Year)

12-03987

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2601 Garrison Boulevard Apt. B Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM 2 1	3. Time of Death
Mark 4a. Facility Name (if not institution, give street and number) 2601 Garrison Boulevard Apt. B 5. Social Security Number 218-86-1094 45. Security Number 218-86-1094 45. Security Number 218-86-1094 45. Security Number 218-86-1094 45. Security Number 218-86-1094 45. Security Number 218-86-1094 45. Security Number 218-86-1094 45. Security Number 218-86-1094 45. Security Number 218-86-1094 45. Security Number 45. Security Number 218-86-1094 45. Security Number 45. Security Number 218-86-1094 45. Security Number 45. Security Number 45. Security Number 46. Sex 47. Age (In yrs. last birthday) 45. Security Number 46. Sex 47. Age (In yrs. last birthday) 48. City, Town, or Location of Death Baltimore 48. Date of Birth (MM And Baltimore 48. Date of Birth (MM And Baltimore 49. Security Number 49. Security Number 408. Oity, Town or Location Baltimore 109. City, Town or Location Baltimore 109. City, Town or Location Baltimore 109. City Town or Location Baltimore 109. City Town or Location Baltimore 109. City Town or Location Baltimore 109. City Town or Location 109. City Town or Location Baltimore 109. City Town or Location 109. City Town	4c. County of Death M/DD/YYYY) 9. Birthplace (State or Foreign Country) MD 10d. Inside City Limits 1 XYes 2 No itizen of What Country? U.S.A.
2601 Garrison Boulevard Apt. B Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MMD 218-86-1094 1 X M 2 F 45 Yrs. Months Days Hours Min. 08 30 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Baltimore 10e. Street and Number 2601 Garrison Blvd 11. Marital Status 1 Never Married 2 Married 2 Married 3 Widowed 4 Divorced II Yes 2 No II Yes 2 No Specify: on Specify: In Yes 2 No Specif	9. Birthplace (State or Foreign Country) MD 10d. Inside City Limits 1 XYes 2 No itizen of What Country?
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2601 Garrison Blvd 21215 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced of Pales: 1 Yes 2 No specify: 1 Yes 2 No specify:	U.S.A.
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1 Never Married 2 Married Armed Forces? 1 Yes 2 No 1 Yes, Sive Year 1 Yes, Sive Year 1 Yes, Sive Year 1 Yes, Sive Year 1 Yes, Sive Year 1 Yes, Sive Year 1 Yes, Sive Year	14. Race - American indian, black,
3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b.	White, etc.
g g laced at 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b.	Specify: Black
15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	Kind of Business/Industry ingling Brother's
Constitution of the state of th	ircus
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidel Party Crawford Betty Crawford	n Surname)
19h Mailing Address (Street and Number of Pural Pouts Number of	City or Town, State, Zip Code)
Betty Hunter-Mother 4001 Clarks Lane #411, Bal 20a. Method of Disposition 1 Bunial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Tempton 1 Date 20c. 15	. Location - City or Town, State
	altimore, Md
21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltime	ore, Md 21215
Physician 23 - fart I. Enter the disease, or a lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh	
Examiner Immediate Cause (Final disease a. Cocaine Intoxication	Death
b	
sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause	
(Disease or injury that initiated Due to (or as a consequence of):	
d. AMENDED 23a,27,28a-f,per me,g928 6-8-12 sm 20b per fb g928 6-18-12 vt	
AMENDED 23a,27,28a-f,per me,g928 6-8-12 sm 20b per fb g928 6-18-12 vt 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy	3d. Date of delivery
23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 1	Month Day Year
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Yes 2 No 9 Unknown 2 Fetal death 3 Ectopic pregnancy 1 Pregnant at time of death 5 Other (Specify) 9 Unknown 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.	
	use contribute to the cause of death?
Yes 2	No 3 Probably 4 ✔ Unknown
24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
24a. Was an autopsy performed? The proof of the proof of	
The state of Death (Check only one) 26. Place of Death (Check only one) 26. Place of Death (Check only one) 4. Place of Death (Check only one)	ence 6 🗸 Other; Scene
The state of the s	jury occurred
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To start a strain of the strai	and Number or Rural Route Number, City 2601 Garrison Blvd.
3 Suicide 6 Could not be determined (Specify) found at home 288. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Apt B Ball Home 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	timore, MD. nd manner as stated.
폭 를 풀 걸 🚨 one) 2 🕡 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pl	
	Date signed (Month, Day, Year)
29b. Signature and title of certifier 29d.	v 26 2012
29b. Signature and title of certifier 29c. License number O.C.M.E. Mai	y 26, 2012
29b. Signature and title of certifier 29c. License number O.C.M.E. 30. Name and address of erson who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	y 26, 2012
29b. Signature and title of certifier 29c. License number O.C.M.E. Mail 30. Name and address of erson who completed cause of death (Item 23a)	y 26, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SSel 30PM 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Hospice Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Months Days Hours (Month, Day, Year) Director 218-32-8202 1 X M 2 □ F Yrs Dec 28, 1937 74 New Jersey Usual Residence of Decedent or 28a-f shov within 72 hours after death with the Maryland 27 is marked other than "netural", or items 23a or 28a-f sho traumatic event, the Madical Examiner must be netfied at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo MD Baltimore Towson 1 Yes 2 X No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 21286 15 Beechleaf Court USA 12. Was Decedent Ever in U.S. Armed Forces? 1 △Yes 2 ☐ No 11. Mantal Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 X Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white If Yes, Give Year or Dates. 3 Divorced 156-59 Completed 15. Decedent's Education 16a. Decedent's Usual Occupation un 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hyglene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) corporate officer Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Russell Lee Childs Catherine Hesse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21286 Marta Harrison/spouse 15 Beechleaf Court Towson, MD item 27 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1
Department of Importent: If it eny injury or o cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 21. Signatur Funeral Service ^{22.} Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Director Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ MOTASTAT 101AR Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🔲 🕦 ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed 31. Date filed (Month, Day, Year) State 5 2012 Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Funeral		5. Social Security N	umber	6. Sex	7. Age (In	yrs. last birth	nday)	If Under 1 Y		If Under Hours	_	8. Date of Bi (Month, D	rth	nel .			State or	Foreign
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of the Hatth and Mental Hygiene Important: If the Azi is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			Carr/sp	ouse			33	W. Main	n S	Stree	t Em	mittsbu	ırg	, MD	217	27		
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		23a. Part 1. Enter t	the disease, or	complications that	caused the	death. Do no										Appl	roximate	
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ding Fih. After funer	Certificate:	1 Accident	5 Pending	9 `	of injury ith, Day, Ye	ear) 28b. T	ime or njury		vork?			28d. Describe	how in	njury occurr	ed			
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier 1 (Check 2	Certifying Medical Ex	Physician: To the base	est of my l	knowledge, o	death o	occurred at the	time,	, date and	l place, a	nd due to the o	cause(s	s) and manr ace, and du	ner as st	ated.	and man	ner stated.
thin 2 the F	_		☐ Certifying	Nurse Practitioner					at th	ne time, da			the ca	use(s) and r	n a nner a	s stated.		
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Hazel L. Dixon June 2012 45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Riverview Care Center Essex Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🕮 Days Dec. 25, 1919 Hours Maryland 216 10 6061 92 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 405 Margaret Avenue 21221 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or iter edical Examiner Armed Forces? Black White etc. ģ 1 Never Married 2 Married Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: 3 ₭ Widowed 4 □ Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Baltimore, County 12 Bus Driver it. Page 1 and 2 should be filed witl rtment of Health and Mental Hygiei rtant: If item 27 is marked other i njury or other traumatic event, t<u>h</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Buck Roberta Altenburg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 405 Margaret Avenue Baltimore, Maryland 21221 Wendy Perkins (Daughter) permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other tr Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2 🖾 Cremation 3 🗀 Removal from State Baltimore, Maryland 4 Donation 5 Other (Specify) Bayview Crematory Inc. 6/6/2012 22. Name and Address of Facility Bruzdziński Funeral Home P.A. 1407 Old <u>Fastern Avenue Essex</u>, . Signature of Funeral Service I Kn W. Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiac Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner un. Known ronz Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year ed by the 9 Unknown ate has been signed page 2 should be det Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Defining high registration to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) M.D 06-05-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D - 21221 709. BASTERN MALIKA WASERM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Leneva

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene

Reg. No. 20 For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month June Day 3, 9:48 PM Ella C. Duff 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Hospital Harford Bel Air 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** May 16, Year 927 85 217-22-2236 Maryland **Director** 1 M 2 1 28a-f show with the Maryland 10a. State 10d. Inside City Limits Director 10c. City, Town or Location notified at MD Harford Bel Air 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be Funeral items 23a 300 Sunflower Dr. Apt. 229 21014 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, vias Decedent Ever Armed Forces? 1 Yes 2 Evio If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married ō by 1 Yes No Specify. "natural", Completed 3 Widowed 4 Divorced Specify. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry age 1 and 2 should be filed within 72. Interest of Health and Mental Hygiene. It if item 27 is marked other than "rry or other traumatic event, the Medi (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Medical Office Clerk Medical Office Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ည Robert Stine Cecelia Geckle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Howard Duff, Jr. /Son 1213 110th St. East Bradenton, FL 34212 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or otl 20c. Location - City or Town, State Jun 05 1 Burial 2 remation 3 Removal from State cemetery, crematory or other place) Chesapeake Crematory Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signarure of Funeral Service Licensee Name and Address of Facility

Cremation and Funeral Alternatives d 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ temorrhy Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate causs. Enter ondenying Cause (Disease or injury Due to (or as a consequence of): Exami that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Completed by Physician/Medical or Attending Physician: The law requires that the death certificate be after death. yes, outcome of pregnancy

Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Dav Pregnant at time of death 1 Yes 2 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? HyperTension 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 IDDA Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending injury n 24 hours arter he Funeral Director. Af 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined Hospital Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Contriving Number Practitionary 1. The contraction my income of a time contraction of the cause of the contraction of the cause of the (Check To the I within 2 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 005 who completed cause of death (Item 23a) (Type, Print) MD Chesapeake De. Beloin MD 21014 eTo Jec Upper 32. Registr State 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 6:02AM Dempsey Sophia Margaret 4c. County of Death
Washington 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Hagerstown Meritus Medical Center If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday 220-20-2641 1 M 2 X F Maryland Dec. 24,1927 84 10c. City, Town or Location Middleton 10b. County 10d. Inside City Limits 10a. State Frederick Maryland 1 Yes 2X No 10f. Zip Code 21769 10e Street and Number 10g. Citizen of What Country? USA 4313 Zircon Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ If Yes, Give Year or Dates 1 Yes 2xXNo Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) City of Ft. Lauderdale Draftsman 12 yr s 18. Mother's Name (First, Middle, Maiden Surname)
Fannie Jameson 17. Father's Name (First, Middle, Last) Doelle ည Charles Jameson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Middletown, MD 21769 4313 Zircon Road Edward C. Dempsey - Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place)
Hurlock Veterans Cem 1X Burial 2 Cremation 3 Removal from State Hurlock, MD June 4, 2012 4 Dopation 5 Other (Specify) unerah Sewice Licenses 22. Name and Address of Facility Baltimore, Maryland 21214 Leonard J. Ruck, Inc 5305 Harford Rd.

Physician/ Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and

attending physician

the signed by

has

Division of Vital Records, P.O. Box 68760

Physician/

Medical

Examiner

Funeral

Director

28a-f show

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if Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me

Department of H Important: If ite any injury or ot

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Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after

> Medical Certificate: To Be Completed by Physician/Medical Examine as the burial-tran nse detached page 2 should the funeral director, within 24 hours after death.
>
> To the Funeral Director: Af completely filled in by the fu

Cr TTOY / / / / / /	THE THE	IICIT C , ICATON,			
23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	cations that caused the death. Do not enter the cause of each line.		or respiratory arres	t,	Approximate Interval Between Opset and Death
resulting in death)	Due to (or as a consequence of): Preymon	12			1 week
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		Dementia		2	1 week
resulting in death) Last	Due to (or as a consequence of).				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		opic pregnancy er (specify)		23d. Date of do Month	elivery Day Year
	tributing to death but not resulting in the underly SION	ying cause given in Part I.			o the cause of death? Probably 4 Unknown
Drabell	ise millitus		24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of
25. Was case referred to medical		26. Place of Death (Chec	ck only one)		
examiner? 1 Yes 2 No	ospital: 1 Inpatient 2 ER/Outpatient 3	□ DOA Other: 4 □ Nursing H	ome 5 🗆 Resider	nce 6 🗆 Other (Spe	cify)
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury N	28c. Injury at work? 1 Yes 2 No	28d. Describe how	v injury occurred	
3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
(Check 2 Medical Examine	bian: To the best of my knowledge, death occur er: On the basis of examination and/or investigation Practitioner: To the best of my knowledge, death	n, in my opinion, death occurred a	at the time, date and	place, and due to the	cause(s) and manner stated.
29b. Signature and title of certifier	1	29c. License number		d. Date signed (Mon	th, Day, Year)

Registrar

31. Date filed (Month, Day, Year,

10

use of death (Item 23a) (Type, Print)

amend #30, per DVR, g928 6-5-12 sm Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Mary	rland / Depa	artment of H	lealth and I	Mental Hy	giene	0 17001
		_	State Registrar		Cer	tificate of [Death		Reg. No. 20	2 17634
	Physicia	n/	1. Decedent's Name (First, Middle, L	.ast)		-		2. Date of Dea		3. Time of Death
	Medic		Kae Dolin	ec				Month 5	3 20	12 12:50 M.
1	Examin	er	4a. Facility Name (if not institution, g	ive street and number)		4b. City, Town, or	Location of Death		4c. County of	
			5. Social Security Number 6	Spital 7 Ago (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	Monto	omery
	Funeral Director		106-22-2194	1 1 M 2 1 1		Months Days	Hours Min.	(Month, Day	y, Year)	Birthplace (State or Foreign Country)
			Usual Residence of Decedent		82 Yrs.			03/08	3/1930	NY
	yland f sho ed at	to	10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits
	Mar 28a- notifie	Director		GOMERY	NORTH	BETHESDA				1 ☐ Yes 2 🔀 No
	th the	틸	10e. Street and Number	2722		10f. Zip Code			10g. Citizen of Wha	at Country?
	ath wi	Funeral	10301 GROSVENO	OR PLACE, APT		Vas Decedent of H	0852	ecify Ves or No-	USA	A service a la disc
'n	or ite	by F	1 Never Married 2 Marrie	Armed Forces?	It	Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		American Indian, White, etc.
000	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	edt	3	If Yes, Give Year or Dates.	1	☐ Yes 2 X No	Specify:		Specify:	WHITE
2-0	2 hou "natu dical	Completed	15. Decedent's (Specify only highest	Education grade completed)		lent's Usual Occup		dina	16b. Kind of Busin	ness/Industry
21215-0036	hin 73 ne. than le Me	E O	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do	O NOT use retired)		9		
	Hygie Hygie ther int, th	Bec	12 17. Father's Name (First, Middle, Las	†)	INT	ERIOR DE		o /Firet & Aidalalla		OR DESIGN
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Merital Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	인	PAUL	PENSKY	Y		MIRIAM	ie (First, Middle,	Maiden Surname)	KANIN
ary.	should be and Meni is marke aumatic		19a. Informant's Name/Relationship			na Address (Street a		al Route Numbe	r, City or Town, State	1
Š	and 2 sh Health ar tem 27 is		MATTHEW DOLINE	R/SON						NY 11201
ore,	of He of He fiter		20a. Method of Disposition	2	0b. Place of Dispo			Date	20c. Location - Ci	
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or oth		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		MT. ARARA			1/2012	EAST FAR	RMINGDALE, NY
salt	permit. Departn Imports any inju		21. Signature of Funeral Service Lio			. Name and Addres			ISON & BRO	
ш	20 E # 5		Muchour 1	ruge					IKESVILLI	E, MD 21208
			23a. Part 1. Enter the disease, or co shock, or heart failure. List onl	omplications that caused the yone couse on each line.	death. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arr	rest,	Approximate Interval Between
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H.	rted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury							
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9 X	th cer ttendi	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr	Fetal death 3	Ectopic pregnand	у		23d. Date of Month	· ·
B	e dea the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time 9 ☐ Unknown	e of death 5 ∟	Other (specify)			Monte	Day Teal
P.O. Box 687	requires that the death certifica been signed by the attending p should be detached for use as		Part II. Other significant condition	contributing to death but no	ot resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribu	ute to the cause of death?
s,	uires t sign lid be	Completed by	Valmonary to	ypertension.				1 🗆	Yes 2 No 3	☐ Probably 4 ☐ Unknown
oro	v requ	olete	Sleen / An	heg.				24a. Was		re autopsy findings available
3ec	sician: The law r certificate has b director, page 2 s	mo:		· · · · ·				autor perfo 1 ☐ Yes	rmed? dea	or to completion of cause of ath? Yes 2 \sum No
a	ian: T rtifica ctor, p	Be C	25. Was case referred to medical examiner?			26. PI	ace of Death (Chec	_	2 2 140	Ties Z E NO
ξ	Physic this ce ral dire	일	1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatier	it 3 🗆 DOA Othe	er: 4 Nursing H	ome 5 🗆 Resid	dence 6 🗆 Other (Specify)
Division of Vital Records,	ing Pl	ate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Yea	28b. Time of injury	28c. Injury work	?	28d. Describe h	now injury occurred	
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ivis	or At after a Direc	Cer	4 Homicide determin	28e. Place of Injury - building, etc. (Sp		eet, factory, office		28f. Location (S City or Tow		or Rural Route Number,
Ω	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transical productions.		29a. Certifier 1 Certifying P	hysician: To the best of my k	knowledge, death o	occurred at the time	e, date and place.	and due to the ca	ause(s) and manner	as stated.
	n 24 h	Medical	(Check 2 Medical Exa	miner: On the basis of exami urse Practitioner: To the bes	ination and/or invest	igation, in my opinio	on, death occurred a	at the time, date a	and place, and due to	the cause(s) and manner stated.
	To the within 2 To the comple		29b. Signature and title of certifier	1 1		29c. License	number		29d. Date signed (A	
			M 160	hut		1000	51302		05/31	/2012
	an		30. Name and address of person wh	o completed cause of death	,	•				
	3		31. Date filed (Month, Day, Year)			own RD. B	ethesda,	MD,20814	4	
	Sta Registr		IUN 0 5 2012	32. Registrar's S	ball					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 31 2012 May George Hobbs Dodson Jr. 03:35 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1875 Poplar Road Annapolis Anne Arundel If Under 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Days Hours 564-35-2021 **Director** 1 X M 2 □ F 37 Yrs. Dec. 12 1974 MD Usual Residence of Decede 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Anne Arundel Annapolis 10e. Street and Number ō 10f. Zip Code 10a. Citizen of What Country? must be with Funeral items 23a 1875 Poplar Road 21401 USA hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", 3 Divorced Specify White Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) within 72 Elementary/Secondary (0-12) College (1-4 or 5+) 9 Swimming Pools Technician is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental မ Page 1 and 2 should be ment of Health and Ments Dodson George Sr. Lorraine Turner traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Department of Health Important: If item 21 any injury or other to <u>Tracey Dodson</u> <u>1875 Poplar Road,</u> Annapolis, MD 21401 (spouse Date 06 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ▼Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June' 2012 Hillcrest Cemetery Annapolis, Maryland 21. Signat 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or com shock, or heart failure. List only of s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician | disease or condition 6. Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or in that initiated events the burial-tran and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23b. Was decedent pregnant 23d. Date of deliven 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autor performe after death.

Director: After this certificate 1 Tes 1 Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Tes Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
1 \(\sum \) Yes 2 \(\sum \) No Natural injury filled in by the Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examper: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

address of person

31. Date filed (Mont)

1:0

empleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 30 20°12 1:20 p M FARMER LOIS Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charles 22 Rivers Edge Terrace Indian Head 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) Months Days Hours (Month, Day, Year) **Director** 212-20-3264 Usual Residence of Decedent 1 🗆 M 2🔽 F 89 Yrs b5 30 23 MD 23a or 28a-f show ast be notified at within 72 hours after death with the Maryland 10a, State 10h Count 10c. City, Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2 🔀 No MD Charles Indian Head 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral must 22 Rivers Edge Terrace 20640 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status "natural", or iter 14. Race - American Indian. Armed Forces' or i Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 ▼ No Specify. 3 Widowed 4 Divorced Specify: Black Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 2th grade Handler Potal Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George H Lee Violia Mikess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20640 Health a Department of Health Important: If item 27 any injury or other tr Patricia Farmer-Daughter Rivers Edge Terrace, Indian Head, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place. Memorial Park 6/8/2012 Woodlawn, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Cancer of Pancreas disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 X Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital. 2 No Other: မ After this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident
Suicid Funeral Director: A 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifiei Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D28352 6/1/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Krishan Mathur, 3500 Old Washington Road Suite 103, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 5 2012 Registrar

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician/ Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

		For State of Marylar	id / Depa	artment of H	lealth and M	-	ene	12 17637
		Registrar 1. Decedent's Name (First, Middle, Last)	Cei	rtificate of E	veatri	Reg 2. Date of Death	. No. 2 U	
Physicia Medic	al	Katherine Frances Fleeks		I		June June		3. Time of Death 9:20 P M
Examin	er	4a. Facility Name (if not institution, give street and number)			Location of Death		4c. County of Howa	
Funeral		6606 Shady Grove 5. Social Security Number 6. Sex 7. Age (In yrs. In the proof of the p	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	g	Birthplace (State or Foreign
Director		218–28–8890 Usual Residence of Decedent 1 □ M 2 🗓 F	Yrs.	Months Days	nours Iviin.	Apr 21,	·	Maryland
show	o		y, Town or Lo	cation		Apr ZII	1555 1	10d. Inside City Limits
8a-f	rect	MD Howard		Colum	bia			1 ☐ Yes 2 🔀 No
a or 2	Funeral Director	10e. Street and Number		10f. Zip Code		100	j. Citizen of Wha	at Country?
ms 2: must	ner	6606 Shady Grove	0 110		044		Inited S	
or ite	by Fu	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	'	Was Decedent of Hi If Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)		American Indian, White, etc.
ural", I Exar		3 Widowed 4 □ Divorced If Yes, Give Year or Dates.		1 ☐ Yes 2 🔀 No	Specify:		Specify:	African American
"nat edica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done d		ng 16	b. Kind of Busin	ness/Industry
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al Hyg d othe vent,	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, Mai		
Ment arked aric e	P	Joel Harris			Katie	Turner		
h and 7 is n traum		19a. Informant's Name/Relationship (Type, Print)	1	ng Address (Street a				e, Zip Code)
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ŀ	Pamela Fleeks / Daughter 20a. Method of Disposition 20b. F	lace of Dispo	Shady Gro				ty or Town, State
int: If		Durial 2 23 Oremation 3 L Nemoval nom State		natory or other place ney Crema	e)			ne, Maryland
spartm porta ny inju	Ì	21. Sign@ure of Funeral Service/Licensee		Name and Addres				
Q = # P		7-7-	1251 B∉	everly L.	Heckrott	e, P.A. (larksvi	ille, MD 21029
ysician/ Medical		23a. Part 1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Advanced	Cardio		g, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death Years
xaminer		Due to (or as a consequence of the conditions of		itis				10 years
_	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		1010				, o years
and	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Myelodyspl. Due to (or as a consequence)						3 years
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within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	~ I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown 23c. If yes, outcome of pregnat 1 ☐ Live Birth 2 ☐ Fets 4 ☐ Pregnant at time of 6 9 ☐ Unknown	al death 3	Ectopic pregnance Other (specify)	у		23d. Date o Month	
ed by	by P	Part II. Other significant conditions contributing to death but not res	ulting in the u	ınderlying cause giv	en in Part I.	23e. Did tobac	co use contribu	ite to the cause of death?
en sig						1 🗆 Yes	2 🛭 No 3	☐ Probably 4 ☐ Unknown
as be	Completed					24a. Was an autopsy	prio	re autopsy findings available or to completion of cause of
icate h						performe 1 \sum Yes 2	d? dea ¶No 1 □	th?] Yes 2 □ No
certif	m	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	50/0 / /:	Othe	r:		- 🗆	
er this	e: 일	27. Manner of Death 28a. Date of injury	28b. Time of injury	28c. Injury	at :	me 5 🔀 Residenc 28d. Describe how i		Specify)
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Directorin by	Certificate:	4 Homicide determined 28e. Place of Injury - At ho building, etc. (Specify		eet, factory, office		28f. Location (Stree City or Town, S		r Rural Route Number,
neral I		29a. Certifier 1 X Certifying Physician: To the best of my know	ledge, death o	occurred at the time	, date and place, ar	nd due to the cause	(s) and manner a	as stated.
the Fu	Medical	(Check 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practitioner: To the best of r	n and/or invest	tigation, in my opinio	n, death occurred at	the time, date and p	lace, and due to	the cause(s) and manner stated.
To Coo		29b. Signature and Atle of certifier		29c. License				fonth, Day, Year)
200	}	30. Name and address of person who completed cause of death (Item	1229) / 5		3671		June 4,	2012
20		Bachubhai Manejwala 14201 Laure	, , , , .	*	rel, MD 2	0707		
Stat	e	31. Date filed (Month, Day, Year) 32. Registrar's Signal						
Registra	r	JUN 0 5 2012 Senewa						

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9, per fh, g928 6-15-12 sm State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 6:50P Physician/ June 2012^{Year} John Fazio 3 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 279 Jenny Drive Carroll Westminster Social Security Number If Under 24 Hrs. 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 235-20-0915 88 Director 1 X M 2 🗆 F Yrs 5-10-1924 -MD Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3061 Bero Rd. 21227 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 Yes 2 No Specify 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Counterman 11 Plumbing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Thomas Fazio Mary E. Tangier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Fazio-son 279 Jenny Dr., Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 6-8-2012 4 ☐ Donation 5 ☐ Other (Specify) Enterprise, WV Enterprise Cem 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home ひ 254 E. Main St., Westminster, MD 21157 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician/ Medical Examiner Sequentially list conditions, Examine Due to for as a nonsectionna of cause. Enter Underlying Cause (Disease or injury ed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day signed by i d be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes page 2 should Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has k autopsy perform 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 Tyes Other: ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 56 5 Residen 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work? 2 No Accident Investigation completely filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day. 90F State 0 5 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2012 Physician/ Month June Fries 3 Beverly 12:30 p ^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1000 Dunholme Road Reisterstown Baltimore 8. Date of Birth

(Month, Day, Year)

June 14, 1942 Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 M 2 K F Country) Maryland Hours Director 213-40-3072 69 Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Reisterstown 1 Yes 2X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 1000 Dunholme Road 21136 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. \$ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 K Widowed 4 Divorced Completed White Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Secretary Solo Cup marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Billmyer Kenneth Jane Louise Deeds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 1 and 2 s of Health in Ella Bikle 10506 Honeyfield Road Williamsport, MD 21795 Cousin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of F Important: If ite 20c. Location - City or Town, State Date 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State 4 Donation 5 Other (Specify) 6/6/2012 Rest Haven Cemetery Hagerstown, Maryland Signature of Funeral Bervice Licenses 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part 1. Ent the disease, or complications that caused the death. Do not enfer the mode of dying, such as cardiac or re shock, or heart failure. List only one cause in each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (ur as a consequence of) Exam Due to (or as a consequence of): attending physician for use as the buria Physician/Medical death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown P.O. þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No Yes 2 N 25. Was case referred to medical of Vital æ 26. Place of Death (Check only one) Hospital: 2 No Other: ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred or Attending 1 Natural
2 Accident
3 Suicide 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Division within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. re and title of certifier License numbe no completed cause of death (Item 23a) (Type, Print) S. Center St, Westminster State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 06:26 AM Garber Tune Norma 2012 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth OCt. 12, 1935 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** Months Days Hours Min. 76 213 50 6123 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show "aumatic event, the Medical Examiner must be notified at 10a, State 10b. County 1 ☐ Yes 2 XNo Director Baltimore Dundalk Maryland 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 7334 Kirtley Rd. 21224 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No Black, White, etc. ☐ Yes Yes, Give 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify ģ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Singer Entertainment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward J. Lurz Sr. Rose Marie Sperzel s 1 and 2 should to f Health and Ment tem 27 is marked 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard M. Garber (Husband) 7334 Kirtley Rd.Baltimore, Maryland 21224 permit. Pages 1 and Department of Healt Important: If item 2: any Injury or other tonce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 6/7/2012 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 ohn 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) use as the burial-transit death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 2 No the Division of Vital Records, P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 1 🗌 Yes 2 No 1 Tyes After this certificate director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 XInpatient Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA မ filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No death. or Attend after death Director: / 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 🗌 Homicide City or Town, State) 24 hours Hospital 29a. Certifier (check only 🕍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) To the 1 within 2 To the 1 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 June, 2, 2012 WW 30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

NWE

MD

32 Registrate Signature

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 17641

		1- For State Registrar	Ce	ertificate c	of Death		Re	g. No.	
Physicia	an/	Decedent's Name (First, Middle,Last)					Date of Deat Month	Day Year	3. Time of Death
Medical Exami		Mathew Nir 4a. Facility Name (if not institution, give	Girdley		4b. City, Town, o	r Looption of D	June 2, 20	4c. County of	0708 hrs
		210 Sudbrook Lane			Pikesville			Baltimore	County
Funeral		Social Security Number 6. Sex		. last birthday)	If Under 1 Year Months Day		Hrs. 8. Date of Bir Min.		Birthplace (State or Foreign
Director		637-07-2910 ¹ X	M 2 F 2	28 Yr		70 110010	Aug 6,	1983	Country) Arkansas
b.		Usual Residence of Decedent 10a. State 10b. County	10c Cit	ty, Town or Loca	ation				10d. Inside City Limits
d how any				- 10	esville				1 Yes 2 X No
Aaryland 28a-f show	용	Maryland Baltime 10e. Street and Number).re	111	10f. Zip Code		10	g. Citizen of Wha	it Country?
the M	Director	210 Sudbrook Lane	<u>.</u>		2120	8		USA	A
with ms 23	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?		as Decedent of Hi		(Specify Yes or No-	14. Race - White,	American Indian, Black,
r death	E	1 X Never Married 2 Married	1 Yes 2 X No				orto radari, oto.)		
rs afte	à	3 Widowed 4 Divorced 15. Decedent's Education (Specify on	If Yes, Give Year or Dates: y highest grade completed)		Yes 2 X No		of work done	Specify: 16b. Kind of Busi	White iness/Industry
2 hou	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		most of working life				,
036 ithin 7 ne. r than	훁	12	04		n/a			n/a	3
5-0 lled w Hygie		17. Father's Name (First, Middle, Last)				18.Mother's N	ame (First, Middle, N		
121 d be f fental arkec	Be	Damian 19a. Informant's Name/Relationship (Ty	Hart	10h Mailir	a Address /Stra	Anna	or Rural Route Num	Malor hor City or Town	
ID 2 shoul and N and N and is m	٩				- ,		Pikesvil	-	
and 2 Tealth item 2	ŀ	Damian Hart/Fat	201	. Place of Dispo	sition (Name of ce		Date		City or Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 X Cremation 3		crematory or o	Cremato		5/4/12	Clan Ru	ırnie, Maryland
altin mit. P partme		4 Donetion 5 Other Specify: Signature of uneration ice Lines		22	Name and Address	s of Facility			
E E E E		Bryan W. Clary	My		O W. Pad	onia Ro	oad⊾ Timor	rium, MD	alley Inc. 21093
Physician /Medical		23a. Part I. Enter in disease, or complifailure. List only one cause on each	h line.		the mode of dying	, such as cardi	ac or respiratory arre	est, shock, or hear	Between Onset and
Examiner		_	Seizure Disor						Death
<i>></i>		b	ue to (or as a consequence	e or):					
	ē		ue to (or as a consequence	of):					
17	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ue to (or as a consequence	of):					
ecuted and transit		d							
'60, cate be exe physician a	Medical	X UNPENDED	AMENDED 23a, 27,	per me,	g930 8-2	9-12 st	<u> </u>		
3760, ificate be g physic s the bur		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pre		etal death 3	Ectopic pro	egnancy	23d. Date of d Month	lelivery Day Year
Box 687 e death certifithe attending ed for use as t	Physician	past 12 months?	4 Pregnant at time of	th	ther (Specify)				
Bo ne dear	ξ.	1 Yes 2 No 9 Unknown	9 Unknown			niven in Deat I	220 Did to	hacea usa contrib	ute to the cause of death?
ords, P.O. w requires that th s been signed by should be detach	by F	Part II. Other significant conditions	contributing to death but no	t resulting in the	underlying cause	given in Part I.			Probably 4 V Unknown
ds, l			· ·					an 24b. W	ere autopsy findings available
tal Records tian: The law requi certificate has been	Completed				_		autop perfor	med? de	ior to completion of cause of eath?
ital Rec ician: The certificate rector, page		OF Man ages referred to modical		_	26 Place	e of Death (Ch	1 Yes	2 No 1	Yes 2 No
Vital ysician his cert	o Be	25. Was case referred to medical examiner?	ospital: 1 Inpatient 2	ER/Outpatier			ursing Home 5	Residence 6	Other: Scene
n of Vil ling Physic After this funeral dir	H-1	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of	Injury 28c. Inju	ury at Work?		now injury occurred	
ion tendin eath. tor: A	텵	1 X Natural 5 Pending 2 Accident Investigation			1	Yes 2 No			
Division of Vital Records, P.O. pital or Attending Physician: The law requires that tours after death. eral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detaa	Certification:	3 Suicide 6 Could not b	e 28e. Place of Injury - At	home, farm, stre	eet, factory, office	building, etc.	28f, Location (8 or Town, S		or Rural Route Number, City
Spital nours a	Se	4 Homicide determined	1 (0,000.9)						
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical		In: To the best of my knowle On the basis of examination	edge, death occu and/or investiga	urred at the time, o ation, in my opinio	late and place, n, death occur	and due to the caus ed at the time, date	e(s) and manner a and place, and du	as stated. e to the cause(s)
To To	Med	29b. Signature and title of certifier	and manner stated.		29c. Licen				d (Month, Day, Year)
		Floor 111	W. J. T.	14.7	0.0	.M.E. (DOME	June 2, 201	2
W		30. Name and address of person who c)				
pend	1	Theodore M. King, Jr., MD.	Assistant Medical	l Examiner	900 W. Baltii	more Stree	t, Baltimore, MD	21223	
St Regist		31. Date filed (Month, Day, Year) JUN 0 5 2012	2. Registrar's Signa	ature	21.				
DHMH 17 Rev 1/2		0011 A 0 7017	para p	ORIGINA	A1				

14

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 2050 2012 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** nter one 8. Date of Birth May 10, 1925 if Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F Hours Min. Days 219-20-5183 Country) Ohio Director 87 Usual Residence of Decedent 23a or 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Examiner must be notified at Director Dundalk Md. Baltimore 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 3477 Dunhaven Road USA or items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc by 1 Never Married 2 Married filed within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify. Specify: White If Yes, Give "natural" Completed 3 X Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mea Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Own Home 12 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Adriana D'onofrio Antonio Morazzano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3477 Dunhaven Road, Dundalk, Md. 21222 John Gentile Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 6, 1 XBurial 2 Cremation 3 Removal from State Baltimore, Maryland Holy Redeemer Cem. 4 Donation 5 Other (Specify) 2012 Signature of Fune Servi 22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23. Part 1. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shoc or heart failure. List only one cause on each line. Interval Between Imir edi de Cause (Final Physician/ dis as or condition Due to (or as a conjuguence of) Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) sician and burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician Medical Box 68760 the attending pl IE FEMALE: 23c. If ves, outcome of pregnancy Physician/ 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) signed by the a d be detached f 1 Yes 2 No g Unknown P.0. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably Lunknown cate has been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 🗌 Yes 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 [Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) funeral To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Dealt 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1- Natural 5 Pending 1 🗌 Yes 2 \square No 2 Accident Investigation 6 Could not be Suicide
Homicide Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, 30. Name and add erson who completed cause of death (Item 23a) (Type, Print)

State Registrar

05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death dent's Name (First, Middle, Last) 2. Date of Death SE Pt ADD Physician/ 2012 June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Harwood Mandrin Inpatient Care If Unde Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours 215-88-0258 Director 1 M 2 - F 1964 Maryland Jan 13. 48 Usual Residence of Decedent or 28a-f show e notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Glen Burnie Anne Arundel MD 10f. Zip Code 10e. Street and Number 10a, Citizen of What Country? f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 1 Funeral United States 21061 45 Bremer Drive Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian 11. Marital Status Black, White, etc. Yes 2 X No Yes, Give Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Fork Lift Operator Warehouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Kav Rabickow Pritchard Gaddy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 304 Ryan Road Glen Burnie, MD 21061 Gaddy / Mother Kay or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot 1 Burial 2X Cremation 3 Removal from State 6/2/2012 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory Woodbine, Maryland 21. Sign we of Funera Coing Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Part 1. Enter the clsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart valure. List only one cause on each line. Approximate Interval Between Onsetiend Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Uncertains Physician/Medical Examine Due to (or as a consequence of): Cause (Disease or injury and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE s, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant Other (specify) Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform page 2 1 Yes 2 director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural 5 Pending work?
1 Yes 2 No s after death. Investigation Accident Suicide the Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Market Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner 15 the best of my movinedge occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completely fi (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death 29d. Date sighed (Month, Day, Year) 29b. Signature and title of certifie 18h 2012 d. ath il em 23a) (T e. Print) Name and a ress of per ANNAPOLIS M WSE HWY TENEVIEVE 31 Date filed (Month, Day, Year, 32. Registrar's Signature State

Registrar

JUN 0 5 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 6:17 P M James Goon June Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Columbia Howard Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 Year If Under 24 Hrs. Birthplace (State or Foreign Days Hours Director 218-26-5267 1**X** M 2 □ F Maryland Usual Residence of Deced 81 Jan 17, 1931 or 28a-f shov notified at 10a. State within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No MD Howard Elkridge 10e. Street and Numbe ò r items 23a or iner must be r 10g. Citizen of What Country? Funeral 5925 Abrianna Way #N 21075 United States n "natural", or iten ledical Examiner n 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed For 1 X Yes Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify Completed 3 Divorced 4 Divorced 1949-53 Asian the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry Human Resource Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygier Important: If item 27 is marked other than any injury or 4 other State Government Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Goon Lee Toy Shim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Constance Goon / Wife 5925 Abrianna Way #N Elkridge, MD 21075 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 6/7/2012 Final Woodbine, Maryland 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ NON-SMALL disease or condition CELL SEPTEMBER 2010 Medical resulting in death) Examiner Sequentially list conditions, if any leading to the cause. Enter Underlying Cause. Enter Underlying Examiner Due to (or as a consequence of Cause (Disease or injury that initiated events attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate 1 ☐ Yes 2 🔀 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No HOSPICE 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 \square Pending injury 1 Yes 2 No Accident Investigation 6 Could not be Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar

DANIEUE

DOBERMAN, MS 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 0 5 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6336

JUNE 2, 2012

COLUMBIA, MD 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Robert Claude Griffith May 4:15 P M Medical 4a. Facility Name (if not institution, give street and number) **E**xaminer 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs. Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Director** 065–34–9030 1 🛛 M 2 🗆 F May 4, 1941 New York 28a-f show 10a. State 10b. County 27 is marked other then "netural", or items 23e or 28a-f sho treumatic event, the Medical Facturies must be potified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 K No Prince George's Silver Spring 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 13013 Firestone Court 20904 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force ģ Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed Specify: 3 Widowed 4 Divorced Caucasian Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Accountant Government Consulting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) buid be file id Mental I marked o ပ္ Griffith Maryemma Leahman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Heaith item 27 i Department of Health Important: If Item 27 eny injury or other the once. Filia Sidarta / Wife 13013 Firestone Ct. Silver Spring, MD 20904 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 6/6/2012 Woodbine, Maryland 21. Signature of Funeral Service Licensee Coing Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Prostate Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physicien and I for use as the buriai-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death signed by the a id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> Records, Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No 1 ☐ Yes 2 ☐ No ☐ Yes Division of Vital Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \boxtimes Other (Specify) HOSPICE 1 ☐ Yes 2 XNo မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ours after deeth, erei Director: Aft filied in by the fur Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signafure and title of certifier R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debrah Miller 6001 Muncaster Mill Rd. Rockville, MD 20855 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 0 5 2012

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 445 PM JERSUK 2012 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE GERIATRIC VINDALE N/AIf Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 ☐ M 2 🛣 F 215-56-6453 68 08/23/1943 Director MD Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits or 28a-f show Examiner must be notified at 1 XYes 2 No Director MD N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number items 23a permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must bonce. Funeral 2434 W. BELVEDERE AVENUE 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. Specify: ģ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NONE NONE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **EDWARD GERSUK** ပ STELLA COHEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUSAN JACOBSON/SISTER 6275 SUNNY SPRING, COLUMBIA, MD20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HAR SINAI CONGR. 05/31/2012 OWINGS MILLS, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ON /Medical Due to (or as a consequence of): Examiner YSPHAGIF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physiclan; The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2√ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient ပ 2 ER/Outpatient 3 DOA After this 27. Manufer of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

within 24 hours after death

To the Funeral Director:
completely filled in by the

State Registrar

0

ETH WHITEFORD JUN 0 5 2012

29b. Signature and title of certifier

But Whitefird, CRA

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

BELVEDEREAVE,

29c. License number

29d. Date signed (Month, Day, Year)

BILTIMORE

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12-0412-	*

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Janiei Nathanie	Па	1- For State Registrar	state of Marylar		rtificate of		u ivientai r		Reg. No. 201	2 1764			
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ilouiou. Exam		4a. Facility Name (if not institut				4b. City, Town, or	Location of Dea	ith	4c. County of Deal				
round		4724 Parkside Drive				Baltimore							
Funeral Director		5. Social Security Number 212-72-4404	6. Sex 7	7. Age (In yrs. 1		If Under 1 Year Months Day		in	15,1958 c	rthplace (State or gn Duntry) MD			
any		Usual Residence of Decedent 10a. State 10b. County	у	10c. City	, Town or Locati	on		-		10d. Inside City Limits			
*	ŗ	MD		E	Baltimo	ore				1 X Yes 2 No			
Maryland 28a-f show d at once.	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of What Cou	intry?			
ith the Maryland 23a or 28a-f sho notified at once.	i D	4724 Parks			a L.o.u.	2120			U.S.A.				
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-fabs traumatic event, the Medical Examiner must be notified at once	/ Funeral	11. Marital Status 1 Never Married 2 X I 3 Widowed 4 D	Married 12. Was Deced Armed Ford 1 X Yes livorced If Yes, Give Year or Dates:		If Y	s Decedent of Hises, specify Cubar	, Mexican, Puer		o- 14. Race - Ame White, etc. Specify:Bla	rican Indian, Black,			
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MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. n 27 is marked other than numatic event, the Medica	To		Pamela Dukes-Hawkins wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 2727 Baltimore MD 21225										
re, N 1 and f Health f item		20a. Method of Disposition	on 3 Pernoval from		Place of Disposi crematory or oth	tion (Name of cer	metery,	Date	20c. Location - City of	Town, State			
Baltimore, permit. Pages 1 an Department of He Important: If ite injury or other tr		Donation 5 Other Specific Metro Crematory 5 une 2012 Catonsville											
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is m injury or other traumatic.		22. Name and Address of Facility Estep Bros. Funera 1300 Eutaw Place Balto. MD 2121											
Physician	0 - 3	2.3. Part Linter the disease, of fair or List only one caus	or complications that cau	ised the ath	. Do not enter th	e mode of dying,	such as cardiac	or respiratory an	rest, shock, or heart	Approximate Interval Between Onset and			
/Medical Examiner		Immediate Cause (Final diseas or condition resulting in death)	se a Hyperte			clerotic	Cardio	vascu1a1	r Disease	Death			
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	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a co	onsequence o	f):								
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760, cate be exc physician the burial	/Med	IF FEMALE: 23b. Was decedent pregnant in	23c. If yes, ou		nancy				23d. Date of deliver				
	Physician/N	past 12 months?	I LIVE DIT	h nt at time of de	oth -	aldeath 3 [ner <i>(Specify)</i>	Ectopic pregr	nancy	Month	Day Year			
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tal Recinant The certificate ector, page		25. Was case referred to medic				26.Place	of Death (Check	1 Yes	2 No 1 Y	es 2 No			
Vita hysicia this ce	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inp	patient 2	ER/Outpatient	3 DOA	Other Nurs	ing Home 5	Residence 6 🗸 Othe	r: Scene			
Division of Vital Records, rate of Attending Physician: The law requir is after death. al Director: After this certificate has been sied in by the funeral director, page 2 should be		27. Manner of Death 1 X Natural 5 Per	28a. Date of (Month, D	Injury ay,Year)	28b. Time of In	``	y at Work? 'es 2 No	28d. Describe	how injury occurred				
Signature of death rector:	icati	2 Accident Inve	estigation 28e Place of	of Injury - At he	ome, farm, stree	t, factory, office b		28f. Location (Street and Number or Ru	ral Route Number, City			
Divi ospital or , hours after neral Dir y filled in I	Certification:		uld not be ermined (Specify)				0.	or Town, S					
To the Hospital Within 24 hours of To the Funeral Completely filled		29a. Certifier 1 Certifying I	Physician: To the best of	of my knowled	ge, death occurr	red at the time, da	te and place, an	d due to the caus	se(s) and manner as stat	ed.			
To th withir To th compl	Medical	one) 2 Medical Ex 29b. Signature and title of certif	aminer: On the basis of e and manner stat	examination a ted.	nu/or investigati	29c. License		at the time, date	and place, and due to tr				
		n _~].				O.C.I			June 1, 2012				
of Dead		30. Name and address of perso	n who completed cause	of death (Item	23a)								
V 1 V		Donna M. Vincenti, M				W. Baltimore	Street, Balti	more, MD 21	1223				
St	ate	31. Date filed (Month, Day, Year	2012 37 Regis	strar's Signat	back	4			 _				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Pate of Death 3. Time of Death 000 Physician/ Month Use Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Randlestown Baltimoe NW Season Hospice Hosp. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral Days Min Hours 219-22-1527 84 **Director** 1 □ M 2 🛣 F 6/6/27 MD Usual Residence of Decedent 28a-f show 10a State 10c. City, Town or Location 10d. Inside City Limits ortant; If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director MD N/A Baltimore 1 🗆 Yes 2 🏝 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21201 903 Penn. ave -USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces African 1 Never Married 2 Married Completed by 2 X No Maryland 21215-0036 72 hours after Yes 1 Yes 2 No Specify. 3 ☐Widowed 4 ☐ Divorced If Yes. Give Amer. Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 hand Mental Hygiene.
7 is marked other than "n Mail life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Geraldine Waddell George Waddell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1400 E. Madison St.#1108, Balt., MD 21205 Department of Health an Important; If item 27 is n Rochelle Allen/Frd Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Balt., MD 6/9/12 Mt. Carmel Cem. 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit Hari P. Close F.Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Funeral Service Lio 23a. Part 1. Enter the disease, o shock, or heart failure. List indications that caused the death. Do not enter the mode of dying, one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence on Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown for Month Year Pregnant at time of death Day the a Unknown signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate has page 2 Yes 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes Other: ဂ္ 1 Inpatient 2 Inpatient 4 Nursing Home 5 Residence 6 Other within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral or 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause State HIN 0 5 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 9:30 AM HARRIS # 12012 4c. County of Death UTARL /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Middle River 8. Date of Birth Dave Hours Min. (Month, Day) Baltmore Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2□F 72 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f ehow Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla nant of Heelth and Mantal Hyglene.
and: If item to 75 is marked other then "natural", or iteme 23a or 28e-1 ehov ury or other treumstic event, the Medical Exercities must be notified at 1 Yes 2 No Riddle Baltimore Directo 10g. Citizen of What Country? 10e. Street and Number 21220 Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 Myes 2 No If Yes, Give Year or Dates: KOREA American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race -11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed by white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Truck RIVER 11 18. Mother's Name (First, Middle, Maiden Surriame) 17. Father's Name (First, Middle, Last) Be Greorge Laura 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Delma Harris 20b. Place of Disposition (Name of 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If eny injury or 22. Name and Addres of 1-ASKON 21. Signature of Funeral Service Licensee RODO DING 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) emosleration Physician Cardio vascular /Medical Due to (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Vnknown icate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner?

1 XYes 2 □ No Be (26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Medical Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier a completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who 6 Trimble Hill MI

Registrar

31. Date filed (Month, Day, Year)

0 5 2012

09304 M

Harris

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2⁰3 May Thomas Edward Hubbard 2012 6:35 P_M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Frederick Memorial Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Director 230-60-1186 1 X M 2 F 1944 67 Virginia July 3 Usual Residence of Decede or 28a-f show 10a. State 10h County 10c. City, Town or Location event, the Medical Examiner must be notified at Director 1 X Yes 2 No Frederick MD Frederick Oe. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 30 North Place 21701 United States or items filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Force Black, White, etc. þ 1 X Never Married 2 Married Yes 2 X No Maryland 21215-0036 1 Yes 2 XNo Specify Yes. Give 'natural", Completed 3 Widowed 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry giene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Construction Painter and Mental Hygier is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ဂ and 2 should be Hubbard traumatic James Mary Greene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Crystal 35 E. All Saints St. Frederick, MD 21701 Stewart / Niece injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot Page 1 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/2/2012 Final Journey Crematory Woodbine, Maryland Signature of Funeral Service License Coing Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23s. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or in that initiated events burial-tran Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as the l IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No detached for Month Pregnant at time of death 5 Other (specify) 9 Unknown 1 ☐ Yes 2 ☐ Unknown ate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an After this certificate has autopsy perform Yes Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certific. completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: ပ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 29b. Signature and title nd address of person who completed cause of death (Item 23a) (Type, Print) FOLL HOUSE Hy, FREDERICK, MD

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

JUN 0 5 201

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 5:55 PM M May Dayle G. Hoeflich

4a. Facility Name (if not institution, give street and number) Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore Social Securify Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday Days Hours Min. Director 214-50-6298 1 □ M 2 🗓 F Jan 15, 1947 Maryland 65 r than "natural", or itama 23a or 28a-f shov the Medicul Evaminer must be notified at 10a. State 10b. County 10c. City, Town or Location fliad within 72 hours after death with tha Maryiand 10d. Inside City Limits Director 1 🗌 Yes 2 🙀 No Baltimore Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 30 Heavrin Court 21236 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ş Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 0 substitute teacher education parmit. Paga 1 end 2 should ba fliad w Dapartment of Heeith and Mantai Hygi Important: if item 27 is merked othe any injury or other traumetic avent, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Irvin Zelem Richardson Louise Mable Prosch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis Hoeflich/spouse 30 Heavrin Court Nottingham, MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) Signatur of Funeral Service License State and Address of Facili Board 655 W, Baltimore Street Baltimore. MD 21201 23a. Part 1. Enter the disease, or complications that caused shock or heart failure. List only one cause on each line. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) . ≰Examiner Sequentially list conditions, if any 1-adm, times at cause. Enter Underlying Cause (Disease or injury Examine Due to for as a nonsequence of To the Hoapital or Attanding Phyalcian: Tha iaw raquiras that tha death carlificata be axecuted within 24 hours aftar daath.

To tha Funarai Director: Aftar this carlificete has baan signed by tha attanding physician and complataly fillad in by tha funarai director, paga 2 should ba datached for usa es tha burial-trensit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 4 Pregnant 9 Unknown 5 Other (specify) Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 XNo မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work?
1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Cer only one ifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of certifier 29b. Signatu 29d. Date signed (Month, Day, Year) 18815000 5-22-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year, State

DHMH 17 Rev 06-2011

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lewis Dewey Hood Month Day 12:30a [™] 2012 <u>June</u> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 143 North Gorsuch Road Carrol1 Westminster Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) Director 216-30-5777 Dec 27 1934 MD Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location items 23a or 28a-f sho her must be notified at 10d. Inside City Limits Director MD Carroll Westminster 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 143 North Gorsuch Road 21157 USA filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, "natural", or ite 1 Never Married 2 X Married ģ Yes 2 X No 1 ☐ Yes 2 X No Specify: Specify:white Completed 3 Widowed 4 Divorced Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) fue1 owner of fuel company other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be fill Department of Health and Mental Important. If item 27 is marked or any injury or other traumatic eve Lewis Dewey Hood Sr. Carol M. Merker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. JoAnn L. Hood (spouse) 143 North Gorsuch Rd., Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) All County Cremation 6-7-2012 Sykesville, MD 22. Name and Address of Facility Haight Funeral Home & Chapel Signature of Funeral Service Licenses Daige Haight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death Immediate Cause (Final Physician disease or condition ars Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death ed by the a detached f g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ þe 1 Tes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an has To the Hospital or Attending Physician: The law autopsy performed? Yes 2 No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify, After this

ည funeral Certificate: within 24 hours after death.

To the Funeral Director: Al
completely filled in by the fu

Maryland 21215-0036

Baltimore,

Box 68760

Division of Vital Records, P.O.

examiner? 27. Manner of Death 1. Natural

5 Pending Accident Suicide Investigation 6 Could not be

3

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of injury

28c. Injury at

work?
1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

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2341

30. Name and address of person who completed cause of death (Item 23a) (Type, Print). Dr Na 113° Baltmore Blvd westmingter 31. Date filed (Month, Day, Year) JUN 0 5 2012

29a. Certifier

(Check only one)

32. Registrar's Signature

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 3Day June 2ď12 7:15A Helen Horner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sykesville Carro11 5329 Wendy Road Social Security Number 9. Birthplace (State or Foreign Country) MD If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Feb 7, 1938 216-34-6648 1 - M 2 X F **Director** 74 Yrs Usual Residence of Decedent 28a-f shov Ħ 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 ☐ Yes 2x No Carrol1 Sykesville MD0 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 23a Funeral 5329 Wendy Road 21784 USA items ? 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 9 þ 1 Never Married 2 X Married 1 Yes 2 XNo Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🟋 No Specify. Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Telephone Company 12 Supervisor and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mildred Virginia Chenworth Patrick J. Cavanaugh 19a. Informant's Name/Relationship (Type, Print)
Mr. Joseph T. Horner (Spouse) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5329 Wendy Road Sykesville, MD 21784 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Lake View Mem. Park 6/8/2012 Sykesville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195 Sykesville, 100764 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ LUNG CANCER SMALL NON disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Records, P.O. Box 68760 the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Day Year Pregnant at time of death g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No page 2 No 1 Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner's Hospital: Other: 1 🗌 Yes 2 🗹 No ည 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of I Director: After to Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation within 24 hours after des To the Funeral Director completely filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature a 00067468 i person who completed cause of death (Item 23a) (Type, Print)
Tang MD 1838 Greene Tv HUESVIlle, MD 21208 Tree Rd Narano

State

Registrar

31. Date filed (Month, Day, Year)

JUN 0 5 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. anend #10c Per FH G928 6/05/2012 Jh State of Maryland / Department of Health and Mental Hygiene 20 | 2 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 06-02-2012 RAMOND HOLMES-WOODS 12 NOON M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HUSPICE GILCHRIST <u>TOWSUN</u> BALIIMORE If Und 7. Age (In vrs. last birthday If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Months Hours Min. (Month, Day, Year) 1 🛣 M 2 🗆 F Yrs 49 03-14-1963 MD 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore - LOCHRAVEN BLVD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5904 LOCHRAVEN BLVD. 21239 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify 3 Widowed 4 Divorced Specify: BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 2YRS CLERK RETAIL INDUSTRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAMES EDWARD HOLMES CATHERINE WOODS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CATHERINE J. HOLCOMBE/MOTHER 1619 INGRAM RD. BALIIMORE, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State DRUID KIDGE Donation 5 Other (Specify) 06-08-12 BALTIMUKE, MU Sign Funeral Service Licenses JAMES A. MORTON & SONS F.H, INC 22. Name and Address of Facility mes a 1701 LAURENS ST., BALTO., MD 2121/ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death disease or condition resulting in death) ing Due to or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year Day

or Attending Physician: The law requires that the death certificate be executed burial-trar physician s the burial Division of Vital Records, P.O. Box 68760 as ttending use ate has page 2 s s after death.

I Director: After din by the fur filled in by 24 hours

Physician/

Medical

Examiner

Funeral

Director

ms 23a or 28a-f show must be notified at

items

"natural", or iten edical Examiner r

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical once.

Physician/

Medical

Examine

ician/Medical

Examiner

permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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eted by Phys		ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown			
Comple			24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
Be	25. Was case referred to medical examiner?	26. Place of Death (Check of	only one)			
10	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hom	me 5 Residence 6 Other (Specify)			
ficate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 28c. Injury at work? 28c. Injury at work? 28c. Injury at work? 28c. Injury at work? 28c. Injury at work? 28c. Injury at work? 28c. Injury at work? 28c. Injury at work? 28c. Injury at work? 28c. Injury at work? 28c. Injur	3d. Describe how injury occurred			
al Certi	3 Suicide 6 Could not be 4 Homicide determined		8f. Location (Street and Number or Rural Route Number, City or Town, State)			
ledica	(Check 2 Medical Examin	sician: To the best of my knowledge, death occurred at the time, date and place, and ner; On the basis of examination and/or investigation, in my opinion, death occurred at the Practitionary. To the best of my knowledge, death occurred at the control of the first order to be the practition.	ne time, date and place, and due to the cause(s) and manner stated			

29c. License number

025205

29d. Date signed (Month, Day, Year)

Type, Print) 6781 N-Cherles St. Balton md 2120x

State Registrar DHMH 17 Rev 06-2011

To the Hosp within 24 hor To the Fune completely fi

29b. Signature and title

BINC

amend #1,per PHY,17,19a,per FH,g928 6-5-12 sm Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Bonita-Jo Horwitz 3. Time of Death Physician/ 1757 PM 2012 HOROUTTS Medical Examiner ility Name (if not institution, give street and number, or Location of Death 4c. County of Death HUNE N/A Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min Director 218-66-1075 1 □ M 2 🗓 F 43 10/19/1968 MD Usual Residence of Decedent or 28a-f show notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? and Mental Hygiene. is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be r Funeral 1925 ROCKHAVEN AVENUE 21228 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) NONE NONE Be Father's Name (First, Middle, Last) **Morris Horwitz** 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev MORRIS HOROWITZ LIBBY GOLDEN 19a. Informant's Name/Relationship (Type, Print)

MORRIS—HOROWITZ/FATHER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 314 CHALK HILL DRIVE, BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OHEB SHALOM MEM. PARK 05/30/2012 REISTERSTOWN, 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Deat Immediate Cause (Final Physician/ ACUTE UPPER disease or condition resulting in death) -HOURS Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 as guipo IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 month 1 Yes 2 No 9 Unknown Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autonsy death? 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examine? Hospital Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 IDOA Division of 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending work? Natural 5 Pending iniury Accident Investigation within 24 hours after death

To the Funeral Director: of completely filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check only one 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) MAY 27, 2012 under mo D2264F 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) I AVENUE BALTIMORE MARYLAND Jerome SNYDER mD. 900 CATON 31. Date filed (Month, Day, Year) - - . State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2012 9:00 AM Ik1e June Μ. Doris Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesda 7010 Glenbrook Road Montgomery 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs **Funeral** Days Months Hours **Director** 131-24-6836 1 □ M 2 🗓 F 84 May 28, 1928 Germany Usual Residence of Decedent or 28a-f show e notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2X No Bethesda Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number I Hygiene. other than "natural", or items 23a or vent, the Medical Examiner must be r Funeral 20814 7010 Glenbrook Road United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married 2 X No þ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) CEO/Economist Energy Efficiency event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental I ျှ Selma Pappenheimer Richard Eisemann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important. If item 27 is any injury or other trau once. 6719 Conway Avenue, Takoma Park, Maryland 20912 Mimi Ikle-Khalsa / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Montgomery Crematorium, Inc. June 5, 2012 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Robert A. Arms and Argument Funeral Home/Bethesda-Chevy Chase, Inc. カル 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 KAR M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final Physician/ disease or condition resulting in death) Ovarian Cancer Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): l by the attending physician and etached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the human death of the season. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Year Day 5 Other (specify) Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 Yes 2 No 2 💢 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospita Other: 1 Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) work? X Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 - Homicide determined Medical XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0026607 June 1, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 06-2011

M.D.

Cullen,

31. Date filed (Month, Day, Year)

7625 Wisconsin Avenue #101, Bethesda, Maryland 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 2012 Physician/ Denise Johnson 11:20pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore, 948 N Franklintown Road Maryland Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔽 F Hours 55Yrs Director /7/1957 217-68-4368 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2000 any injury or other traumatic event, the Madical Concession of the contract of the cont 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No NA Baltimore MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 948 N. Franklintown Rd. 21216 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 Married Š African 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Behavior Tech 12th Chimes Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George E. Johnson, Sr. Felina Booker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Johnson - Sister Denison St. Balto... 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 6/7/2012 Catonsville, Md. 21, Signature of Funeral Service Licensee Wylie Funeral Homes, P.A. Gilmor Baltimore. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) ue to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a consequence of): ff any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🖾 No Month Dav Year Other (specify) Pregnant at time of death signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes cate has been significated to page 2 should to 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 KResidence 6 Other (Specify) 1 🗆 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To within 24 hours after death.

To the Funeral Director; After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 2 and address of person who completed cause of death (Item 23a) (Type, Print) Battimore MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland department of Health and Mental Hygiene. In filem 7: In marked other than "natural", or items 23s or 28s-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number				10f. Zip Code			10	g. Citize	en of What			
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Bal permi Depa Impo		21. Signature of Auterial Service	11824 Reisterstown									n.	MD 2	1136
Physician		23a. Part I. Enter the disease, or failure. List only one cause	complications that cau	sed the death								,	Approxin	nate Interval
(Medical Examiner	W W	Immediate Cause (Final disease	a. Hypertensive			ovascular Di	sease					_1		Death
\$		or condition resulting in death)	Due to (or as a co	onsequence o	of):									
	ner	Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause	Due to (or as a co	onsequence o	ıf):									-
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence o	f):			_				-		
executed an and al - transit	al E		d									\dashv		
E. č 5 . E.	edical	UNPENDED	AMENDED									_		
6876C certificate nding phys	M/u	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, ou			al death 3	Ectopic p	regnancy			Date of del onth	ivery Da	y	Year
Box 68760 e death certificate b the attending physical ed for use as the bu	Physician/Me			it at time of de	eath 5 Oth	er (Specify)								
the de by the ched f	Phy	Part II. Other significant conditi	9OINIOW		esulting in the ur	iderlying cause	given in Part	1.	23e. Did tob	acco us	e contribut	e to th	e cause o	f death?
Records, P.O. Box 68760. The law requires that the death certificate rate has been signed by the attending physage 2 should be detached for use as the b	d by		_		•						No 3 🗸			Unknown
rds requi	lete							_	24a. Was a					gs available of cause of
of Vital Records, ag Physician: The law require this certificate has been similared director, page 2 should be	Completed							_	perform	ned?	deat		2	
LL	BeC	25. Was case referred to medical examiner?	41 21				of Death (C	heck only	one)			,		
Physic Physic er this	P	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inp		ER/Outpatient 28b. Time of In		Other ₄ h	Nursing Ho			ce 6 🗸 C	ther: S	cene	
e# _ `~	Certification:	1 V Natural 5 Pendi	(Month, D	ay,Year)	ZOD. TIME OF III		ryatvvork? Yes 2N	1	Describe ho	ow injury	occurred			
Division tal or Attendi rs after death.	ifica		tigation 28e. Place of	of Injury - At ho	ome, farm, street	, factory, office b	ouilding, etc.		Location (St		Number o	r Rura	Route N	umber, City
Di spital tours a	Cert	4 Homicide determ	mined (Specify)						or Town, Sta	ate)				
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical		ysician: To the best on the basis of e										ause(s)	
To I	Med	29b. Signature and title of certifier	and manner stat	ed.		29c. Licens					ite signed			ar)
		10/1,	111	19	1	O.C.	M.E.				2, 2012			
	ŀ	30. Name and address of person v	•	,	•									
		والموالية ومعمون	ssistant Medical	Examiner strar's Signatu		altimore Stre	et, Baltim	ore, MD	21223					
St Regist	ate	31. Date filed (Month, Day Year)	2012 Z	suar s oignatu	back									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 31, 2012 ay Mary S. Kindrick 11:05 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Keswick Multi Care Center Baltimore N/A Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 406-14-6539 93 **Director** 1 □ M 2 XXF KY March 15, 1919 Usual Residence of Dece or 28a-f show notified at 10b. County 10c. City, Town or Location 10d, Inside City Limits within 72 hours after death with the Maryland 10a. State rector N/A MD Baltimore 1 XXYes 2 □ No ۵ 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a o Funeral U.S.A. 609 West 40th Street 21211 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedo... Armed Forces? 1 ☐ Yes 2XX No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XXNo Specify. Specify 3XXWidowed 4 ☐ Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry Hygiene. other than " rent, the Mes life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Ith and Mental Hygiene 27 is marked other the traumatic event, the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) S Oscar Dillard Storie Polly Duncan Page 1 and 2 should I ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Marilyn Julius (Daughter) 609 West 40th Street Baltimore, Maryland 21211 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Atlantic Crematory 4 Donation 5 Other (Specify) 6/2/12 Glen Burnie, MD re of Funeral Se 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Balto, MD 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician. Cerelyo vesulor a. Hemmarnasic disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Dav Year be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s performed? Yes 2 No 1 🗌 Yes 2 🗆 No the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 1 Yes 2 100 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending work? 24 hours after death. Funeral Director; A 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho **To the Fune** completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and till of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

s of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

D0059056

Wist you St Belt NO 21211

6/1

20/2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland	d / Department of H		lental Hyg	giene	17661			
		_	Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of L	Jeath	2. Date of Dea	Reg. No. 2016	17001			
	Physicia Medic	al	William H. Kir	mmich			1, ^D 2012 Year	3. Time of Death 4:50p M			
Ì	Examir	er	4a. Facility Name (if not institution, give street and number) Gilchrist Hospice Center		r Location of Death		4c. County of Dea Balt	imore			
	Funeral Director		5. Social Security Number 492–16–2482 Usual Residence of Decedent 6. Sex 1 🔀 M 2 🗆 F	st birthday) If Under 1 Year Months Days Yrs.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) June 1	Year) 9. Bir	thplace (State or Foreign untry) Iissouri			
	Maryland 28a-f shov otified at	irector	10a. State Md. 10b. County Baltimore 10c. City,	Town or Location Dund	alk			10d. Inside City Limits 1 ☐ Yes 2 🛣 No			
	h with the	Funeral Director	10e. Street and Number 7128 Martell Ave.	10f. Zip Code	21222		10g. Citizen of What Co USA	ountry?			
9800	e flied within 72 hours after death with the Maryland tall Hygiene. ad other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No	in, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.			
212	within 72 ho giene. ier than "na it, the Medic."	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10 years	16b. Kind of Business. Baltimore							
yland	should be filed and Mental Hy is marked oth aumatic event	To Be	17. Father's Name (First, Middle, Last) Robert Kimmich		18. Mother's Name Mary		Maiden Surname) bernathy				
, Mar	ge 1 and 2 should be it of Health and Men If item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type, Print) Martha Kimmich Wife	19b. Mailing Address (Street a 7128 Martell	and Number or Rura Ave, Dun	dalk, Ma	City or Town, State, Zip d. 21222	o Code)			
imore	permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra		1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State	ace of Disposition (Name of metery, crematory or other plac view Crematory		12, 12,	20c. Location - City or Baltimore,				
Ball	21. Sign ture of Fineral Service Lizence 22. Name and Address of Facility Connelly Funeral Home of Dundalk, 7110 Sollers Point Road, Dundalk										
F	hytician/							Approximate Interval Between Onset and Death			
	Medical Examiner	J.	resulting in death) Due to (or as a consequel Sequentially list conditions,								
	ecuted and -transit	dical Examiner	If ony leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
09,	ate be executed oblysician and the burial-transit	edical E	d.	Tice 01).							
P.O. Box 687	to the hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No g □ Unknown 23c. If yes, outcome of pregnance 1 □ Live Birth 2 □ Fetal of 4 □ Pregnant at time of decent 1 □ Unknown	death 3 Ectopic pregnanc	y		23d. Date of de Month	ivery Day Year			
ds, P.0	quires that t en signed b ould be deta	by	Part II. Other significant conditions contributing to death but not result	ting in the underlying cause giv	ven in Part I.		pacco use contribute to	the cause of death?			
Division of Vital Records,	nysrcian: The law rentis certificate has be	Completed				24a. Was ar autops perform 1 \(\sum \) Yes	med? prior to death?	topsy findings available completion of cause of			
ita	sician; certifi irector	m	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 Fl	Othe	ace of Death (Check		,	11201			
n of V	ding Phys th. After this funeral d	cate: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year)	R/Outpatient 3 DOA 8b. Time of injury 28c. Injury work	4 ☐ Nursing Ho / at		ence 6 🗹 Other (Spec w injury occurred	ity) HOS pice_			
)ivisio	al or Atten s after dea I Director d in by the	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be determined			28f. Location (St. City or Town	reet and Number or Ru , State)	ral Route Number,			
)	ne Hospita in 24 hours ne Funeral pletely fille	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled to the best o	and/or investigation, in my opinio	 n. death occurred at 	the time, date an	d place, and due to the	ause(s) and manner stated.			
	vith To th										
	101		30. Name and address of person who completed cause of death (Item 2. SYED Q. ABBAS MD 6701 N	29c. License D7. 3a) (Type, Print) Charles Street	- Seuli 4	105 Bo	ellimore N	1021204			
ē.	Stat Registra	•	31. Date filed (Month, Day, Year) 32. Figistrar's Signatur	8. parks							

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Linthicum Tate House If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Funeral Social Security Number Hours (Month, Day, Year) Director 220-62-5660 1 □ M 2 🖾 F 1953 July 25 Pennsylvania 58 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Yes 2 No Crownsville MD Anne Arundel 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21032 United States 1569 Severn Chapel Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black White etc. ☐ Yes 2 🛣 No Yes, Give Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 Divorced Caucasian Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Legal Secretary Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gloria Heller Jack Kurtz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1569 Severn Chapel Road Crownsville, MD 21032 Daniel Moos / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 6/6/2012 Woodbine, Maryland Final Signature of Fuperal Sen Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 Wort 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METKETKIL ANCER Physician/ disease or condition resulting in death) Cays Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cauca. Extra Uncertains Cause (Disease or injury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed eral Director: After this certificate has been signed by the attending physlcian and filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 4 ☐ Pregnant at time of death g ☐ Unknown 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy hours after death. Ineral Director: After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 🗆 Nursing Home 5 🗆 Residence 6 🗷 Other (Specify) rate HOSPICE 1 🗌 Yes 2 **N**No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural Accident 5 Pending Investigation 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ŀ 4 MO 00036581 112 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 445 Defense Highway Annapolis, MD 21401 31. Date filed (Month, Day, Year)
JUN 0 5 2012 32. Registrar's Signature

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	1 - State Registrar Cell	rtificate of Death	, ,	g. No. 2012	17663
	Physicia Medic	_	1. Decedent's Name (First, Middle, Last) Patricia Ann Kennedy		2. Date of Death Month June 1	Day 2012 Year	3. Time of Death 3:45 p M
)	Examin		4a. Facility Name (if not institution, give street and number) 3190 Sharp Road	4b. City, Town, or Location of Death Glenwood		4c. County of Death Howard	1
	Funeral Director		5. Social Security Number 212-50-4767 6. Sex 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,) Jan 23	9. Birt 1952	hplace (State or Foreign untry) MD
	faryland 8a-f show tified at	Director					10d. Inside City Limits 1 ☐ Yes 2 X No
	with the N s 23a or 28 ust be not	Funeral Dir		10f. Zip Code 21738	10	og. Citizen of What Co USA	untry?
9800	e filed within 72 hours after death with the Manyland tal hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 Never Married 2 X Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: whi	e, etc.
21215-0036	vithin 72 hou piene. er than "nat the Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Corp	dent's Usual Occupation kind of work done during most of work O NOT use retired) Orate treasurer	ing	olumbing &	
Maryland 2	uld be filed v Mental Hyg narked othe natic event,	To Be	17. Father's Name (First, Middle, Last) Charles Klein Sr.		e (First, Middle, Ma s Andes	aiden Surname)	
	2 shouth and the and the and traum		Mr. Charles T. Kennedy (spouse) 3190		od, MD 21	1738 	
Baltimore,	permit. Page 1 and Department of Heal Important: If item any injury or other once.		4 Donation 5 Other (Specify) Old Holy	rnatory or other place) Family Cem. 6-7-	12 I	Randallstor	wn, MD
Bal	permit Depar Impor any in			2.Name and Address of FacilityHai 2.0. Box 195 Sykes			Chapel
	Medical Examiner	ī	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (final disease or condition resulting in death) a. Due to (or as a consequence of): Sequentially list conditions,	er the mode of dying, such as cardiac Myeloma Yozathy	or respiratory arres	it,	Approximate Interval Between Onset and Death 1960
3760 %	ificate be executed g physician and as the burial-transit	Physician/Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	fibrillation			6 months
. Box 687	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-trans	าysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Pregnant at time of death 5 Unknown	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of del Month	ivery Day Year
ls, P.O.	requires that the been signed by should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
		Completed			24a. Was an autopsy perform 1 Yes 2	prior to death?	topsy findings available completion of cause of
Vital	> .00 0		25. Was case referred to medical examiner?	26. Place of Death (Checont 3 DOA Other:		nce 6 🗆 Other (Spec	ify)
	Attending Physician: If death. Setor: After this certific by the funeral director,	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) 28b. Time of Death (Month, Day, Year)	f 28c. Injury at work? M 1 ☐ Yes 2 ☐ No	28d. Describe hov	v injury occurred	
≥	i Sire		3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rui State)	ral Route Number,
	To the Hospital or within 24 hours after To the Funeral Director completely filled in	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or investonly one) 3 Certifying Nurse Practitioner: To the best of my knowledge	stigation, in my opinion, death occurred a	t the time, date and	I place, and due to the	cause(s) and manner stated.
	To the with To the the the the the the the the the the		29b. Signature and title of pertifier \mathcal{M} \mathcal{D} .	29c. License number \$\int 000 6.543c\$	29	June 4	2012
	0		30. Name and address of person who completed cause of death (Item 23a) (Type, I 4201 Dorsey Hall, Dr, ElliCott City	29c. License number \$\int 006543c\$ Print) Uliana Keta 1, Md, 21042	Selar	200 m.D	
	Sta Registr		31. Date filed (Month, Day Year) 32. Registyr's Significant				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5 Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Mandrin Hospice House Harwood Anne Arundel 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 9. Birthplace (State or Foreign Hours Days Months Country) 108-20-4022 Director 1 M 2 X F 84 New York Feb. 1, 1928 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 15 marked outher than "natural", or items 23a or 28a-f sho amportant: If item 27 15 marked outher than "natural", or items 5.2a or 28a-f sho amportant: In item 25 15 marked outher than "natic event, the Mo-lical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland | Anne Arundel Millersville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8049 Veterans Highway, Lot 15 21108 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married ğ 1 ☐ Yes 2 ☒ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Completed 3 Nidowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frederick Thomas Bertha Langdon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. Wines / Son 7104 Renwick Ct., Glen Burnie, Maryland 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 2012 cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗔 Removal from State 4 Other (Specify) Crownsville MD Vet. Cem. Crownsville, Maryland Signature of Funeral Se Name and Address of Facility
rkley-Ruddick Funeral Home, P.A.
1 Crain Hwy., S.E., Glen Burnie, MD 21061 01 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. AILURE Immediate Cause (Final Physician/ disease or condition resulting in death) TE Medical Due to (or as a consequence of) Examiner NE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transli Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Day signed by the at d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CORONARY ARTERY Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CONGESTIVE HEART 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 N funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 Ø No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred eral Director: After filled in by the funer Hospital or Attending 1 Natural 2 Accident injury 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Detaying Priystoan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Detaying Priystoan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number m e and address of person ppleted cause of death (Item 23a) (Type, Print) LICHAEL 31. Date filed (Month, Day, Year) State Registrar

Box 68760

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Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Aquinas Keelan, Jr. 262012 7:25 PM Thomas May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 24 Courthouse Square, Unit 612 Rockville Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗶 M 2 🗆 F Days Hours Min 579-28-9802 83 June 8, Y 1928 Washington, DC **Director** Usual Residence of Decedent Show mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ordants I filem 27 is marked other than "natural", or items 23a or 28a-f sho ordants I filem 27 is marked other than "natural", or items 25a or 28a-f sho ordants I filem 27 is marked outher than "natural", or items 25a or 28a-f sho 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Rockville 1 X Yes 2 No Maryland Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 24 Courthouse Square Unit 612 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Ves 2 No 1952If Yes, Give
Year or Dates. 1955 Black, White, etc. 1 Never Married 2 Married by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 X Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Denistry Orthodontist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Veda Marie Cleary 2 Thomas Aquinas Keelan, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 1934 Kamuela, Hawaii, 96743 Thomas Vincent Keelan/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of June 3, 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott . Page 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) Bethesda, Maryland 4 Donation 5 Other (Specify) Montgomery Crematorium, Inc. 2012 22. Name and Address of Facility Robert A.Pumphrey Funeral Home Rockville, Inc. 300W.Montgomery Avenue Rockville, Maryland 20850 21. Signature of Funeral Service Lig-Willer M01173 s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. 23a. Part 1. Enter the disease, or complicati Approximate Interval Between shock, or heart failure. List only o Immediate Cause (Final Onset and Death Physician Mouse disease or condition lens. Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to for as a nonsequence dry Exami Hospital or Attending Physician: The law requires that the death certificate be executed trar Due to (or as a consequence of) burialphysician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Dav Year ped the ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has page 2 s autopsy certificate 2 No 1 Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After injury 5 Pending 1 Natural Accident work? 1 ☐ Yes 2 ☐ No n 24 hours after death.

Ie Funeral Director: Ai
oleted filled in by the fu Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

State Registrar 29a. Certifie (Check

only one

29b. Signature and title of certifie

31. Date filed (Month, Day, Year 32. Registrar's Signature JUN 0 5

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

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Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

ocks

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

6106,96

29c. License number

12-04126	
Helen Kuo	

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible

lelen Kuo	1- For State	tate of Maryla	nd / Depart				Hygiene	21	012 1766
Physician	Registrar 1. Decedent's Name (First, Midd	lle,Last)		10010 01	Death		2. Date of De	Reg. No. eath	3. Time of Death
ledical Examin		Kuo					Month May 31,	Day Yea 2012	1226 hrs
	4a. Facility Name (if not institution	· -	ber)	4	o. City, Town, or L	ocation of De	eath	4c. County	
~	Shady Grove Hospita				Rockville	1		Montgor	
Funeral Director	5. Social Security Number		. Age (In yrs. last	birthday)	If Under 1 Year Months Days		Min		9. Birthplace (State or Foreign
	213-56-1220	1 M 2 X F	79	Yrs.			Nov.	17, 1932	Country) China
*BDY	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Location	n				10d. Inside Cify Limits
≧	Maryland Monte	romo 817	N E	Oo thoo i	اما				1 Yes 2 X No
Aaryland 28a-f show	10e. Street and Number	gomery	I N. E	Betheso I	10f. Zip Code	-		10g. Citizen of Wh	nat Country?
tth the Maryland 23a or 28a-f sho notified at once.	11710 Old Geo	rgetown Ro	ad #1117		20852			United	States
with as 23, be not		12. Was Deced	dent Ever in U.S.	13. Was	Decedent of Hispa	anic Origin?	(Specify Yes or N		- American Indian, Black,
death r iten	11. Marital Status 1 Never Married 2 M	arried Armed Ford	ces?	If Ye	s, specify Cuban,	Mexican, Pue	erto Rican, etc.)	White	e, etc.
after	3 X Widowed 4 Div	orced If Yes, Give Year		1 .	res 2 X No	specify:		Specify:	Asian
5-0036 led within 72 hours a Hygiene. other than "natural the Medical Examin					S Usual Occupations of working life. I			16b. Kind of Bu	siness/Industry
36 in 72 han "	Elementary/Secondary (0-12)	College (1-4	or 5+)	•			,		**
15-0036 Flied within 72 hour Hygiene. d other than "natte the Medical Example Committed Commit	17. Father's Name (First, Middle,	Last)			omemaker	Mother's No	me (First Middle	Maiden Surname)	n Home
215 be filed ntal Hy rked o		, 2201,			"		Yu Fong	, Maider Surname,	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Health and Maretal Hygiene. Important: If then 27 is marked other than "matural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.		hip (Type, Print)		19b. Mailing	Address (Street a			mber, City or Town	n, State, Zip Code)
MD id 2 should and and and 27 is a sum at	Stella Kuo/Da	ughter		605 A	rgyle Ci	rcle,	Wynnewoo	d, Penns	ylvania 19096
Te, l and l'Heal	20a. Method of Disposition 1 Burial 2 X Cremation	2 Demand 6			on (Name of ceme	etery,	Date		City or Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	4 Donation 5 Other St				rematorium	1 J	Tune 6, 2012	Bethes	sda, Maryland
alti mit. partm ports ury o	21. Signature of Funeral Service								a-Chevy Chase, Inc
C FOR	Millian P.	Tunshely	M011	' ~ / ככ/ ~ '	WISCORSI	n Avenu	e. Bernesd	la. Marvian	d 20814
Physician // // // // // // // // // // // // //	23a. Part I. Enter the disease, or failure. List only one cause	complie tions that chu on each line.	sed the death. Do	not enter the	mode of dying, su	uch as cardia	ic or respiratory ar	rest, shock, or hea	rt Approximate Interval Between Onset and
Examiner	Immediate Cause (Final disease or condition resulting in death)		lyte Disc	order :	followin _j	g Cerv	ical Lam	inectomy	Death
- with		Due to (or as a co		c					
i i	Sequentially list conditions, if any, leading to immediate	Due to (or as a co		3					
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ox 68760, eath certificate be attending physic for use as the bursician/Med	IF FEMALE:	23c. If yes, out	come of pregnanc	су				23d. Date of c	delivery
687 certifing ding	23b. Was decedent pregnant in th past 12 months?	Li Live Dirti	n t at time of death		death 3	Ectopic preg	gnancy	Month	Day Year
	1 Yes 2 ✔ No 9 Unk	nown 9 Unknow		5 Othe	(Specify)				
		ons contributing to de	eath but not result	ting in the und	lerlying cause give	en in Part I.	23e. Did t	obacco use contrib	oute to the cause of death?
8 99 9	Hypertensive A	<u>Atheroscler</u>	otic Car	rdiovas	cular Di	isease	1 Ye	s 2 No 3	Probably 4 V Unknown
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Records, The law requires ficate has been sig page 2 should be Completed							_ autop perfo	rm <u>ed</u> ? de	ior to completion of cause of eath? Yes 2 No
tal Relician: The certificate ector, page	25. Was case referred to medical				26.Place of	Death (Chec		2 10 1	Yes 2 No
Physiciant this control of the B		Hospital: 1 Inpi	atient 2 🗹 ER/	/Outpatient	DOA Ot	her ₄ Nur	sing Home 5	Residence 6	Other:
ling Ph	27. Manner of Death	28a. Date of (Month, Da	Injury 28b ay, Year)	o. Time of Inju	ry 28c. Injury a	at Work?	28d. Describe	how injury occurre	d
ttend ttend death. ttor: / the f	1 X Natural 5 Pend 2 Accident Inves	ing tigation			1 Yes	2 No			
Division of Vital Records, spital or Attending Physician: The law requirements after death. After this certificate has been similar in by the funeral director, page 2 should be Certification: To Be Completed	3 Suicide 6 Could	THOU DE	f injury - At home,	farm, street,	factory, office build	ding, etc.	28f. Location (or Town, 8		or Rural Route Number, City
		(Gpeciny)							
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	(Check only 1 Certifying Phone) 2 Medical Exar	ysician: To the best or niner:On the basis of e							
To To Sign	29b. Signature and title of certifier	and manner state	ed.		29c. License n	umber		29d. Date signed	(Month, Day, Year)
	Corse L	LADDAW			O.C.M.	OCM E.	E	June 1, 201	
On I	30. Name and address of person	who completed cause of	of death (Item 23a))				1	
end		Assistant Medical			timore Street	, Baltimor	e, MD 21223		
State	11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2012 32. Fagis	trar's Signature	par	2)				
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ CLIFTON CHARLES KELLER 8:31 PM 2012 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** at ake Dice 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth g, Birthplace (State or Foreign **Funeral** 1 **⊠** M 2 □ F Days Hours Min 09 30 1 Country) 30 215 8481 76 **Director** MD Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No MD Dorchester Rhodesdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 5340 Wesley Rd 21659 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) n "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married þ 2 No Yes If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed White Baltimore, Maryland 21215-0 the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business Industry Industrial Elementary/Seconday (0-12) 10 College (1-4 or 5+) Steamfitter Construction h and Mental Hygier 7 is marked other t traumatic event, Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clifton Andrew Keller Angelina Venanzi permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5340 Wesley Rd Steven Keller -Rhodesdale. MD20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 6/4/2012 Baltimore, 22. Name and Address of Facility GJ Gonce Funeral Home, 21. Signature of Funeral Solvice Licensee 21122 Riviera Drive Pasadena, MD 23a. Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ OBSTRUCTIOR MILMONA HRONIC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year should be detached the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1) Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performed 1 Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No Hospital: PISR ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Other (Specify Manner of Death Natural 28a. Date of injury 28b. Time of Certificate: 28c. Injury at within 24 hours after death.

To the Funeral Director: After (Month, Day, Year) 5 Pending work? 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check -Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) DO058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WARS 130 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible/In/2 Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Jun Day 03 Physician/ OSI7M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death University of Mary and Medical Cente Baltimue N/A Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) 383-34-2446 Director 1**X** M 2 □ F 15 1935 Germany 76 May 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo 1 🗌 Yes 2 🗐 No Dundalk Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2017 Bear Ridge Road, Apt. 204 USA 21222 Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. White Specify: Completed 3 ☒ Widowed 4 ☐ Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) IBM Computer Programer 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Grams Willi Kleg Herta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 <u> Irene Kasprzyk</u> (daughter) 201 Armstrong Lane, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June Date Department of I-Important: If ite any injury or ot once. 04 cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Metro Crematory Inc. 2012 21. Signature of Funeral Service Lic 22. Name and Address of Facility Stallings Funeral Home, 3111 Mountain Road, Pásadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events the burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical P.O. Box 68760 for use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Year Pregnant at time of death the 9 Unknown 9 I Inknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? within 24 hours after death.

To the Funeral Director. After this certificate has lead to the funeral director, page 2 completely filled in by the funeral director, page 2. performed Yes 2 No 1 🗌 Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🗌 Yes 2 No ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year, use of death (Item 23a) (Type, Print) Suite 510, Baltimar, MD State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar		Cert	tificate of	Death			Reg. No.		
Physic			le,Last)			-		2. Date of D	eath	V	3. Time of Death
Medical Exam	inė	Jacquerine	Laster					Month May 25,	Day 2012	Year	1701 hrs
. 1		4a. Facility Name (if not institution	n, give street and nu	ımber)	4	b. City, Town,	or Location o	f Death	4c. C	ounty of Death	1
		University Hospital				Baltimore			N	[/A	
Funera Directo		5. Social Security Number	6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Ye Months Da		r 24Hrs. 8. Date of Min.	Birth(MM/DD	9. Bir Foreig	thplace (State or
Director	ſ	216-96-4791	1 M 2 X F	47	Yrs.	WOTERS	iys Hours		3/196		untry) MD
b]	Usual Residence of Decedent							- / - 0 0		
w any	ı	10a. State 10b. County		10c. City, 7	own or Location	on					10d. Inside City Limits
Aaryland 28a-f show 1 at once,	5	MD Balt	imore	Pi	kesvil	lle					1 X Yes 2 No
Mary 28a-	5	10e. Street and Number				10f. Zip Code			10g. Citizer	of What Cou	ntry?
death with the Maryland or items 23a or 28a-f sho	Funeral Director	3924 Rolling	Road -	Apt 9		2120	8		USA		
h with mas 2.	era	11. Marital Status	12. Was Dec	edent Ever in U.S		Decedent of H	lispanic Origi	n? (Specify Yes or I		. Race - Ameri	can Indian, Black,
deat! or ite	Ė	1 X Never Married 2 Ma	arried Armed Fo	2 X No	If Ye	s, specify Cuba	an, Mexican,	Puerto Rican, etc.)		White, etc.	
after after incr			orced If Yes, Give Yea or Dates:	ır	1 🗌	Yes 2∑X N	o s <i>pecify</i> :		Sp	ecify: B	lack
5-0036 fed within 72 hours after Hygiene. other than "natural", the Medical Esseminer	P6	15. Decedent's Education (Spec	cify only highest grad	de completed)		s Usual Occupa st of working lif		ind of work done	16b. Kind	of Business/I	ndustry
6 127 1	Completed	Elementary/Secondary (0-12)	College (1	-4 or 5+)			e. DO NOT u	ise retired)	1		
within tene.	Ę	12			Waitı	ess			Res	taura	nt
Hys the	ŭ							Name (First, Middle		,	
21215-0036 ald be filed within 7 Mental Hygiene. marked other than e event, the Media	Be		aster				Car	olyn V.	Last	er	
MD 2:1215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 77 is marked other than "natural", or items 23a or 28a-f she mastic event, the Medial E. mainer must be notified at once	ပ္	19a. Informant's Name/Relations			19b. Mailing /	Address (Stre	et and Numb	per or Rural Route Nu	ımber, City o	or Town, State,	Zip Code) 21208
무 등 등 등		Carolyn V. 20a. Method of Disposition	<u>Laster</u>	Look Di	3924 ace of Dispositi	No.Ro	lling	<u> </u>	<u>),Pik</u>	<u>esvil</u>	<u>le,Md.</u>
E E of R Z		1 X Burial 2 Cremation		om State	ematory or other		emetery,	Date	20c. Loc	ation - City or	Town, State
im Pag ment tant: or of		4 Donation 5 Other Sp	ecify:		utus M	lemori	al	6/4/2012	BAI	timore	∍ Md
Baltimo permit. Pago Department Important: injury or ot		21. Signature of Funeral Service	Licensee	11/1	22. N a	me and Addres	Broth	ers Fune	ral	Servi	ce DA
		Eugen Ma	Hrand 11	14X		.5000111	тяти Р	I aca Ka	1 1 mo	ro Ma	d. 21217
Physician		23a. Part I. Enter the disease, or failure. List only one cause	complication's that ca on each line.	used the death. D	o not enter the	mode of dying	, such as car	rdiac or respiratory a	rest, shock,	or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. Gunshot Wound to Head									
		or condition resulting in death)	Due to (or as a	consequence of):							
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	ine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	consequence of):							
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executed an and al - trans			d								
	/Medical	UNPENDED	AMENDED								
760, ficate be g physici	/Me	IF FEMALE:	23c. If yes, o	utcome of pregnar	ncy				23d. Da	ate of delivery	
68 ertifi iding	ian	23b. Was decedent pregnant in the past 12 months?	LIVE DI		_ =	death 3	Ectopic p	pregnancy	Moi	nth Da	ay Year
Box 687 e death certifithe attending led for use as t	Sic	1 Yes 2 No 9 ✔ Unkr		ant at time of death	5 Othe	r (Specify)			13		
P.O. Be that the de ned by the detached f	Physician	Part II. Other significant condition	<u> </u>		Ilting in the unc	lerlying cause	niven in Part	1 23a Did i	Obacco uso	contribute to t	ne cause of death?
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Division of Vital Records, talor Attending Physician: The law requirers after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be	P	1 ✓ Yes 2 No	Hospital: 1 🗸 In	patient 2 EF	R/Outpatient 3	DOA	Other 1	Nursing Home 5	Residence	6 Other:	
fing Pl		27. Manner of Death	28a. Date o (Month, J May 24, 2	f Injury 28 Day, Year)	Bb. Time of Inju		ry at Work?	28d. Describe		ccurred	
ior ttend leath.	ij	Pendii	ng May 24, 2	2012	804 hrs	1 1,	Yes 2 🗸 N	Subject sho	,,		
or A or A Direc	릛			of Injury - At home	e, farm, street,	factory, office b	uilding, etc.	28f. Location (Street and N	lumber or Rura	al Route Number, City
D ours ours filled	Certification:	4 V Homicide determ	nined (Specify)	Townhouse /	Rowhouse			or Town, S 2500 W. Fay	ette Street,	Baltimore, N	I D
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		29a. Certifier 1 Certifying Phy	ysician: To the best	of my knowledge,	death occurred	at the time, da	ate and place	and due to the cau	se(s) and ma	anner as stated	1.
Fo th Vithir Compl	Medical		Iner: On the basis of and manner sta	examination and/ ated.	or investigation	ı, in my opinion	, death occu	rred at the time, date	and place, a	and due to the	cause(s)
- > - 0	Ž	29b. Signature and title of certifier				29c. Licens	e number		29d. Date	signed (Mont	h, Day, Year)
		U M.	1/			O.C.I	M.E.		May 27	, 2012	
	ŀ	30. Name and address of person w	no completed cause	of death (Item 23	a)						
4 V		Jack Titus MD. Depu	aty Chief Medica	al Examiner	900 W. Ba	ltimore Stre	et, Baltim	ore, MD 21223			
		31. Date filed (Month, Day, Year)	32. Reg	istrar's Signature	13		_				
Regist	rar	.IIIN 0 5 2012 /	Zueva K	7. park							

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Gustave John Leidig Physician/ 9:05 A.M. Wanth Qu Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BAltimore Washington Medical Center Glen Burnie Anne Arundel . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours Country 217-09-9469 Director 1 XXM 2 - F 91 MD Dec 24, 1920 27 is merked other than "natural", or items 23a or 28a-f show traumatic event, it e Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Glen Burnie MD Anne Arundel 1 🗆 Yes 2XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21060 U.S.A. 7994 Stone Haven Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ TVV Yes 2 No Baltimore, Maryland 21215-0036 3 ₩Widowed 4 □ Divorced 1 ☐ Yes 2xxx No Specify: Completed Specify: White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene, Is merked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12th Designer Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Edith Jeffords Charles G. Leidig permit. Page 1 and 2 should be Department of Health and Men. Important: If Item 27 is merke any Injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Leidig (Daughter) 7994 Stone Haven Drive Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XX remation 3 Removal from State 6/5/12 Glen Burnie, MD Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burgee Henss-Seitz Funeral Home, Inc. Signature of Funeral Se 3631 Falls Road Balto, MD 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one use on each line Immediate Cause (Final Onset and Beath Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical æ examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, doctors. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MM20/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) filed (Month, Day, Year) State JUN 0 5 2012 Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mav Month Physician/ 2012 Rosalie Ann Long 26 8:30 AM M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Frederick Examiner 4b. City, Town, or Location of Death Frederick 302 Canberra Court 8. Date of Birth (Month, Day, Yea Jan. 19, Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours 217-32-6729 Maryland Director 1 □ M 2 🔯 F 1938 74 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehow any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Frederick Frederick Maryland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 302 Canberra Court U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3

Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Clothing Factory 10 Seamstress Be 18. Mother's Name (First, Middle, Maiden Surname) Anna Margaret Mowery 17. Father's Name (First, Middle, Last) Charles I. Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 302 Canberra Court, Frederick, MD 21701 Ms. Diana Long, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ronal of 22 Name and Address of Facility Board 655 W. Baltimore Street Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin , such as cardiac or respiratory arrest, shock, or heart failure. List only one cause un each line. Interval Between Immediate Cause Final disease or condition resulting in death) Onset and Death Physician/ Herr Medical Due to (or as a consequence of) , Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) ettending physicien and i for use as tha buriel-transi Hospital or Attending Physician: The law requires thet the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day 24 hours efter death.

• Funeral Director: After this certificate hes been signed by the eletely filled in by the funeral director, page 2 should be deteched it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No Yes 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🗌 Yes 2 🗀 No Investigation 6 Could not be ☐ Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May Month 28^y Clergie Eileen Lull 2012 08:00 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 442 Maryland Avenue Pasadena Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Feb. 04 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 - M 2 X Months Days 220-24-9384 Country) Director 85 Yrs. 1927 WV Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Anne Arundel Pasadena 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 442 Maryland Avenue 21122 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any piury or other traumatic event, the Medical Examiner musonce. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 X Widowed 4 □ Divorced Specify: Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 6 <u>Homemaker</u> Household Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Thomas Murphy Ada Hopermill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Sparks (daughter) 442 Maryland Avenue, Pasadena, MD 21122 20a. Method of Disposition Date 31 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) May 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Cemetery Glen Burnie, Maryland 2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of,: if any, leading to immediate cause. Enter Underlying ned by the attending physician and detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be-sty hours after death.
 Funeral Director. After this certificate has been signed by the attending physicis received filled in by the funeral director, page 2 should be detached for use as the burneled filled in by the funeral director, page 2 should be detached for use as the burneled. Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day Unknown ntributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy performed? Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\sum \) No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending injury 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \square Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Within 2 To the F 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

4304

MOUNTAIN LD, PASADENA, MY 21122

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GAR6

MA

RADEE

31. Date filed (Month, Day,

amend #4b, per phy, g929 7-9-12 sm
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
nend #9 Per FH G928 6/11/2012 Jh
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Morris Mai 201 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Date of Bir Medical A. A Avunde len 7. Age (In yrs. last birthday) 79 Yrs. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Alabama **Director** Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh must be notified a 1 Tes 2 No owle 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral Knowledge 20715 iral", or items ? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 2 100 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced Specify. Completed Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) DIOL WKer Be Eather's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 0 Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Knowledge Nonderlin MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important; If ite any injury or ot 1 Surial 2 Cremation 3 Removal from State 2012 4 Donation 5 Other (Specify) ritaa Signature of Fun al Service L censes 2. Name and Address of 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) oneumonio Medical Tue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or liniury Examiner Due to (or as a consequence of) for use as the burial-transit that initiated events resulting in death) Last an Due to (or as a consequence of) signed by the attending physician Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Day Pregnant at time of death Month Year completed filled in by the funeral director, page 2 should be detached Unknown 9 Unknown P.O. significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Funeral Director; After this certificate has autopsy perform 2 🗌 No 1 🗌 Yes Yes 2 Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No 1 🗌 Yes Other ပ္ 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Accident (Month, Day, Year) 5 Pending 1 Tyes 2 \square No Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours after Medical to Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Cortifying Nurse Practisper: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 2gb. Signature and title 0 29d. Date signed (Month, Day, Year) 58510 30. Name and address of person who completed cause of State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of D **Baltimore Baltimore** 608 Queensgate Road Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 🗆 M 2 🗎 F Months Days Hours MD Mar 11, 1930 217-24-8013 Director Yrs items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits

1 Yes 2 No Director **Baltimore** MD **Baltimore City** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 608 Queensgate Road U.S.A. 11. Marital Status Was Decedent Ever in U.S. Was Decedo...
Armed Forces?

Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🗓 No **Black** If Yes, Give Year or Dates 3 🗷 Widowed 4 🗌 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **Pebbles Pub** Chef 12 Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 2 Frances Wright William Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 608 Queensgate Road Baltimore, MD 21229 April Bracken 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Jun 12, 2012 Owings Mills, Md. **Garrison Forest Veterans** 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility
 Estep Brothers Funeral Service, P. A.
 1300 Eutaw Place Baltimore, Md 21217
 23a. Part - Enter the disease, or complications that caused t e death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate

Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year be detached Unknown 9 🗌 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autops perform death? 1 Yes 2 🗸 funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 1 No P 1 🗌 Yes Other: this 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Mannei 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes Accident the Investigation within 24 hours after death To the Funeral Directors. Sulcide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Beverly McCullough 3:30PM Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death HOSPita etimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) MD **Funeral** Age (In vrs. last birthday) Month Day Year 1951 1 🗆 M 2 🗖 F **Director** 215-60-5151 60 Usual Residence of Decede 28a-f show : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director **Baltimore** MD **Baltimore City** Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country Funeral 21215 3415 Olympia Avenue U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedon Armed Forces? ¹ ☐ Yes 2 No 14. Race - American Indian, McCulbuah, Beverly Black, White, etc by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. **Black** If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Case Worker **Dept. of Social Services** 12 permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jane Thomas Matthew McCullough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3900 Chatham Road, Baltimore, MD 21207 Tyrone Williams 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Jun 07, 2012 Baltimore, Md. Woodlawn Cemetery & Chapel 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Juneral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Part 4. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician Coronari disease or condition Medical resulting in death) Due to (or as a consequine of): Examiner Sequentially list conditions Examine Due to (or as a consequation of) if any Lacing to immedicause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or injury that initiated events resulting in death) Last be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year Pregnant at time of death 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No 1 Yes filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) a No Certificate: To 1 Tes Other 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sino

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

JUN 0 5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Moore Physician/ Month William tine 2012 0611A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Air Harford If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours Min **Director** 203-40-6659 1 🔀 M 2 🗆 F Aug. 30, 1950 Pennsylvania 61 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 X No Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 316 Blackburn Court Joppa USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status ian "natural", or itei Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify: Specify. White 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Industrail Supplies Sales Representative Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 Matthew Thomas Moore Marion Francis Brady 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 901 Joppa Farm Road, Joppa, MD 21085 Carrie Dorman / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, Maryland Rose Hill Svcs, LLC 6-11-2012 Signature of Funeral Service Licenses McComas Funeral Home, P.A. 22. Name and Address of Facility 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Interval Between Onset and Death Immediate Cause (Final Acute Myocardia Interction Physician/ disease or condition Medical resulting in death) Communy Vascular Disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) resulting in death) Last Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Hypotensium, Ohesity Physician: The law requires 1 Tes 2 No Probably 4 D Unknown Division of Vital Records, 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? Director: After this certificate 1 Tes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ျှ ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide City or Town, State) MOORE within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. SOO Unner Chexpenhe Drive; Bel Aw, mD 2101C Q

DHMH 17 Rev 06-2011

State Registrar

M800 294

12-04138 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Calvin Matthew, Jr. State of Maryland / Department of Health and Mental Hygiene 2012 1- For State Certificate of Death Reg. No Registrar 2. Date of Death nt's Name (First, Middle,Last) 3 Time of Death Physician/ Month Day May 31, 2012 2149 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center Baltimore 5. Social Security Number 6. **Se**x 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Country) Months Days Hours Min Director 1 V M 2 F 15-17-708 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MOr mit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland partment of Heath and Mental Hygiene, protrant: If teath and Mental Hygiene, protrant: If teath 27 is marked other than "natural", or items 23a or 28a-f sho irry or other traumatic event, the Medical Examiner must be notified at once Director 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 11. Marital Status 2. Was Decedent Ever in U.S Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 1 Yes 2 No 1 Yes 2 No specify: 4 Divorced If Yes, Give Yeer \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 00 17. Father's Name (First, Middle, Last) å 19b. Mailing Address ို (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name (Relationship (Type, Print) Father) 20b. Place of Disposition (Name of cemeter) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation crematory or other place) 3 Removal from State 4 Donation 5 Other Specify. emeten meland Address of Facility 21. Signature of Funeral Sea 40 m M Approximate Interval he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one Between Onset and /Medical Death Stab Wound of Chest Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transi Physician/Medical UNPENDED **AMENDED** IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed Records, 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? Yes 2 No 1 Yes 2 No 26.Place of Death (Check only one) To the Hospital or Attending Physician: director. 25 Was case referred to medical of Vital Be Other Nursing Home 5 Residence 6 Other: Inpatient 2 ER/Outpatient 3 DOA 1 Ves this ဥ 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury After 27. Manner of Death 28a. Date of Injury Certification Subject assaulted May 31, 2012 Natural 2105 hrs Division 1 Yes 2 V No death. 5 Pending the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 24 hours after 3 Suicide Could not be or Town, State) 3000 Block of East Preston Street, Baltimore , MD determined To the Funeral (Specify) Local Street 4 🗹 Homicide Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within ? and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 1, 2012

Registrar

State

OCME

32. Registrar's Signature

ORIGINAL

Assistant Medical Examiner

900 W. Baltimore Street, Baltimore, MD 21223

30. Name and address of person who completed cause of death (Item 23a)

Carol H. Allan, MD

31. Date filed (Month, Day, Year)

12-04198		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	1767
Antoneo Donte M		1- For State Cartificate of Death	1/6/
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Anoth Day Year	e of Death
1		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Hospital Baltimore	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (In yrs. last birthday)	
Director		214-92-7521 1 M 2 F 42 Yrs. 15 19 1970 Country) V Usual Residence of Decedent	10.19.10.10.1
d K			side City Limits Yes 2 No
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be potified at once.	rector	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
ith the 23a or	at Di	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indi	an Black
leath w	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	i
s after rral", o	à	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: 5 Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry	K
72 hour	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	
5-0036 led within 7 Hygiene. other than	Completed	12 Electronic Technician Wards Mac	hinzry
ID 21215-0036 should be filed within 72 hours after de and Mental Hygiene. 7 is marked other than "natural", or natic event, the Medical Examiner m	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 18. Mother's Name (First, Middle, Maiden Surname)	n '
D 21 should b and Mer	2	19a. Informant's Name/Relationship (Type, Print Daugnter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co.	de)
nore, MD 2 ages 1 and 2 shou nt of Health and N tt: If item 27 is n other traumatic	ŀ	Mrs. Jasmine Love 2713 Oakley Ave. Battimore Mo 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery) Date 20c. Location - City or Town, S	21215 tate
MOTE, Pages 1 a nent of He ant: If ite		1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify:	MD
Baltimore, M pemit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traun	Ì	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Russ Funeral Home, P. A	, , ,
Physician	-		eximate Interval
/Medical Æxaminer		Immediate Cause (Final disease a. Multiple Injuries	een Onset and Death
LAUIIIIICI		or condition resulting in death) Due to (or as a consequence of): b.	- 1
	Iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause	
si d	Exam	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
178 g g g	ا ه	d. UNPENDED AMENDED	
760, cate be physici	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 4 Live birth 23c. If yes, outcome of pregnancy 4 Month 23d. Date of delivery 23d. Date of delivery	
Box 68760, c death certificate be the attending physic ed for use as the bur	ician	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	Year
the deat	Physician/Medic	Yes 2 No 9 Unknown Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause	e of death?
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be ext. After this certificate has been signed by the attending physician tumeral director, page 2 should be detached for use as the burial-	6	1 Yes 2 No 3 Probably 4	
of Vital Records, ag Physician: The law requin ther this certificate has been si meral director, page 2 should be	Completed	24a. Was an 24b. Were autopsy fin autopsy prior to completic	
Reco	S	performed? death? 1 Ves 2 No 1 Ves	2 No
/ital sician: is certif	å	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other Wursing Home 5 Residence 6 Other:	
n of V ding Phy L After th funeral	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Yaar)	
	catio	2 Accident Investigation	a Number City
Divi	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Local Street 28f. Location (Street and Number or Rural Route or Town, State) 1200 Block East Lafayette Avenue, Baltim	
		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. One) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
Tot with Totl	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day,	
		The don the tring JA, M. D. O.C.M.E. OGME June 3, 2012	
7		30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
Sta	ate	31. Date filed (Menthe Par, Near) 32. Registrar's Signalures	
Regist	rar	JUN 0 5 2012 Kenery P. 1900	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 30 Regina Rita Murphy 8:00 A May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 12261 Roundwood Rd. Baltimore Timonium Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 M 2 😾 Months Hours 87 Maryland Director 219-12-5922 Dec 1924 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits with the Maryland notified at Director 28a-f 1 Yes 2 X No Baltimore Timonium Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 21093 USA 12240 Roundwood Road, 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Force Black, White, etc. ö þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: Specify "natural" Completed 3 X Widowed 4 Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 n/a Homemaker Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ т. Rykowski Eleanor Bagac Joseph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timonium, MS 21093 12240 Roundwood Road, #802, Susan Reier/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/31/2012 Glen Burnie, Maryland Atlantic Crematory 21, Signatur Clary 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 23a. Part 1. Enter the rease, or complications that caused he death. Do not enter the mode of dying, such as a shock, or hear fail re. List only one cause of each line. Interval Between Immediate Cause Fin-Onset and Death Ph_sician/ disease or conditi Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate being the rough of the stern death.
Funeral Director: After this certificate has been signed by the attending physicial eted filled in by the funeral director, page 2 should be detached for use as the bure. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Thknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No Yes 2 X No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 🗖 Other (Sp. 2 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number City or Town, State) completed filled in by determined Medical 29a. Certifier crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

within 2 To the F Registrar

JUN 0 5 2012

d tille of certifie

Susan Meltzer, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

only one) 29b. Signature as

16918 York Rd., Suite 100, Hereford, MD

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, Year,

For State Registrar

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

3. Time of Death

2. Date of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 ear Physician/ Metzger June 7:25P M Barbara 1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Dundalk 7613 Gum Road Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Maryland 1 □ M 2 🂢 F 214-56-8722 61 February 7, Director Usual Residence of Decedent show 10d Inside City Limits 10b County 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at the Maryland Funeral Director Dundalk Baltimore Maryland 1 Yes 2 X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 7613 Gum Road USA permit. Page 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene.} Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonee. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status Armed Forces? 1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Hospital Community Psych Patient Registrar 12 years 2 vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Viola Anna Bisesi ပ Irvin Lester Hook Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Husband 7613 Gum Road, Dundalk, Maryland Joseph Metzger 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June Bate 6. cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Baltimore, Maryland Oak Lawn Cemetery 2012 4 Donation 5 Other (Specify) Signature of F n al Service Lio Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 Approximate Interval Between Onset and Death 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Breast Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant for in the past 12 months?
1 ☐ Yes 2 🕱 No Month Day Year Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the sector, page 2 s autopsy performed Yes 2 X No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 XNo 1 Inpatient 2 ER/Outpatient 3 IDOA ည 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director; After completed filled in by the funer 1 Natural 2 Accident work?
1 Yes injury 5 Pending 2 🗌 No Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and to ss of person who completed cause of death (Item 23a) (Type, Print) 12, 30. Name and

State

VEBO

0 5 2012

31. Date filed (Month,

0 0.

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2012 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 28 0000 M 2012 Ludwell Lee Miller III Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner MD BALTIMORE AGNES MOSPITAL 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Director 218-44-7754 1 **X** M 2 □ F 66 Nov 18. Maryland Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes 27 No Catonsville MD Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? must be Funeral 23a21228 USA 209 Rollingdale Road tems death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Examiner Armed Forces? ò þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: white Specify: "natural" Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 0 banker financial event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည Ludwell Lee Miller Jr Grace Adele Strohmeyer traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains 21228 Linda Miller/spouse 209 Rollingdale Road Catonsville, MD altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Signature of uneral Service Licensee State Anatomy Board 655 W. Baltimore Street Raltimore, MD 21201 23a. Palt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease o ondition resulting in th) Physician TROKE MONTH Medical **Examiner** NEUMONIA scale of the state Examine Due to (or as a consequence of use as the burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ate has been signed by the atte page 2 should be detached for Year Month Dav 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Junknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No Director: Af er this certificate 1 Yes 2 No To the Hospital or Attending Physician: the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Tyes Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 2 Accident Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Division of Vital Records,

State Registrar

filled in by

Medical

within 24 hours a

To the Funeral C

completely filled

4 🗌 Homicide

31. Date filed (Month, Day, Year)

JUN 05

29a. Certifier (Check

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AGRAWAI

MD

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

126388

Certifying Nurse Practitioner: to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

CATON AVE BALTIMORE, MD 21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 310PM ine Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Date of bill. (Month, Day,) If Under 1 Year . Age (In vrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 💢 F Hours 50 226-08-8369 VA **Director** April 196 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director VA Harrisonburg 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be i Funeral USA 4675 Cromer Road 22802 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Force Black, White, etc. 1 Never Married 2 X Married þ 2 X No Maryland 21215-0036 ☐ Yes If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify. Specify: white 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mee once. than, Elementary/Seconday (0-12) College (1-4 or 5+) health care nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Daniel Jacob Beard Jean Alice Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 4675 Cromer Road, Harrisonburg, Virginia 22802 Jay Nelson Moyers (husband) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 ☐ Cremation 3 X Removal from State 6-5-2012 4 ☐ Donation 5 ☐ Other (Specify) Lindale Cemetery Linville, VA Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel ▶ Parge Starght Box 195 Sykesville, MD 21784 0. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph, i i.n. disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 performed? certificate 2 \square No 1 Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 1 Tyes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural 5 \square Pending work 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 2012 me and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar

or 28a-f show e notified at o ral", or items 23a o Examiner must be "natural", and Mental His marked of

State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 0110 Delores Malkus Medical JUNE 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOSpital + Bathmore Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Months Hours Min (Month, Day, Year) Director 214-24-0749 1 🗆 M 2 🕱 F 84 10/23/1927 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5713 Emelia Avenue 21206 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 X Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) P Department of Health and Meni Important: If item 27 is marke any injury or other traumatic Η. Clark Elmira Shackelford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Geiger, Daughter 5512 McCormick Avenue Baltimore, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Svc. Corp. 06/04/2012 Towson, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimroe, MD 21214 lexandra Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician metartatic lelyomiosarcomd c disease or condition Medical resulting in death) Due to (or as a consequence of): Pleural extlisions 1 month Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or) burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1) pertenian hopeviridemia 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate it completely filled in by the funeral director, pag performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) H DIPICE ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year, MO RES 000 June 2, 2012 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)
SUNNER PATE MD SINA HD PHAL & BALTIMOVE 2401 W Belvetere Ate Britimore MD 32. Registr r's Sign State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 05 Physician/ 2012 6:52 p M Morton Darwin Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Calvert Prince Frederick Calvert Memorial Hospital 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** 92 212-14-1129 Washington, DC **Director** 1 X M 2 - F 02/06/1920 Usual Residence of Decedent 28a-f show 10d, Inside City Limits 10a. State 10c. City, Town or Location 10b. County other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Charlotte Hall St. Mary's MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? U.S.A. items 23a 20622 29449 Charlotte Hall Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc Armed Forces? "natural", or þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 rt Yes, Give Year or Dates, 1945–46 White 1 Yes 2 X No Specify 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Dispatcher Trucking 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) ျ Fones Edward Morton Minnie Ellen Clifford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O.Box 218 Forest Hill, MD 21050 Dennis Morton, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State Dulaney Vålley 06/04/2012 Towson, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc 5305 Harford Road Baltimore, MD 21214 Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atheroscleno Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** ardiovasculas disease Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Hospital or Attending Physician: The law requires that the death Day signed by the at Id be detached fo g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ Preumon/a Hspiratiun 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Acute Upper Gastro-Entestinal Blueding 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsv has performed? Aure Renal Failure After this certificate the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Na Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 🔀 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No after death. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Atter within 24 hours after des To the Funeral Director completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D.50653 an. C. o wong

State Registrar werch ten

32. Registrar's Sign ture

GYAN

Roads

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deale

31. Date filed (Month, Day, Year, JUN 0 5 2012

C. SURANA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc g928 6-28-12 vt
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Paul E. Matsos Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Holland Manor Towson . Sex 1 M 2 □ F Social Security Number If Under 1 Year Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 2/22/1939 Vear 213-34-4531 **Director** Greece Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Mary land Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21234 U.S.A. 26 Kintore Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc 1 X Never Married 2 Married Yes 2X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Merchant 12 Seaman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Maria Diakou Emmanuel Matsos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emmanuel B. Matsos / Nephew 26 Kintore Court Baltimore, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 X Burial 2 Cremation 3 Removal from State Greek Cemetery 6/4/2012 4 Donation 5 Other (Specify) Woodlawn, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Proveician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death cate has been signed by the page 2 should be detached g Unknown 9 Unknown Part II. Other, significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 🗌 No Yes 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🖵 No ဂ္ 1 Tes 4 Nursing Home 5 Residence 6X Other (Specify) Assisted Liv this 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director, After Natural 5 Pending 1 🗌 Yes 2 🗐 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title ise of death (Item 23a) (Type, Print) State Registrar

12-04091 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. John Clinton Morris State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day May 30, 2012 **Medical Examiner** 1145 hrs John Clinton Morris 4a. Facility Name (if not institution, give street end number 4b. City, Town, or Location of Death 4c. County of Death 403 S Mount St Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) Funeral Foreign Country) Days Director Hours 216-90-8675 1 X M 2 F 49 04/06/1963 MD Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c, City, Town or Location 1 Yes 2 TNo rmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ppartnent of Health and Montal Hygiene, paratural?, or items 23a or 23a-f she inportant: If item 27 is marked other than "natural?, or items 23a or 23a-f she jury or other traumatic event, the Madical Examiner must be notified at once in yor other traumatic event, the Madical Examiner must be notified at once Maryland Anne Arundel Glen Burnie Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 109 Scott Avenue 21060 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? White, etc. 1 Never Married 2 Married Yes 4 Divorced If Yes, Give Year 1 Yes 2 No specify: White Specify: \$ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 Carpenter Construction 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Albert Morris Sr. Phyllis Johnson 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code).

7466 East Furnace Branch Rd., Apt 205 MD 21060 ည 19a. Informant's Name/Relationship (Type, Print) Phyllis Morris (mother) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State June 05 1 Burial 2 X Cremation 3 Removal from State Baltimore, Maryland Metro Crematory Inc. 2012 4 Donation 5 Other Specify 21. Signature of Funeral Service Lice 22. Name and Address of Facility Stallings Funeral Home, 3111 Mountain Road, Pasadena, MD 21122 P.A. Enter the dise e, or compli o not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** re. List only one caus on each line. Between Onset and /Medical Death a Heroin and Alcohol Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): and Physician/Medical AMENDED 23a, pt. II, 27, 28a-f, per me, g928 6-8-12 sm **X** UNPENDED ned by the attending physician detached for use as the burial -Hospital or Attending Physician: The law requires that the death certificate be Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Cocaine Use Completed Division of Vital Records. 24a. Was an 24b. Were autopsy findings available autopsv prior to completion of cause of has page 2 s performed? death? Yes 2 No 1 🗸 Yes 2 No After this certifi-funeral director. 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene 1 Yes 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year Certification: 1 Natura 1 Yes 2 X No unknown 5 Pending within 24 hours after death.

To the Funeral Director: completely filled in by the fd 5-30-12 fd 11:31 am 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 X Could not be Suicide or Town, State) 403 S. Mount St. (Specify) Homicide Found: in vacant row home Baltimore, MD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registra DHMH 17 Rev 1/2001

OCME 2006

State

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

29c. License number

O.C.M.E.

and manner stated

29b. Signature and title of certifier

Ling Li, MD

4

5 2012

30. Name and address of person who completed cause of death (Item 23a)

29d. Date signed (Month, Day, Year)

May 31, 2012

12-04184 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Hari Khemthand Nichani State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 3. Time of Death Month Day June 2, 2012 Medical Examiner Harilal K. Nichani 1349 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Howard Howard County General Hospital Columbia 5. Social Security Number 6 Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In vrs. last birthday) Foreign Country) India Months Days Hours Director 439-35-2741 01/03/1935 1 M 2 F 77 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 Yes 2 No Oadby Leicester HK mit. Pages I and 2 should be filed within 72 hours after death with the Maryland partment of Health and Mental Hygiene.
portant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10e, Street and Number 10g. Citizen of What Country? 21 Chestnut Drive Stretton Hall 1e24qx Canada 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes 2 X No Specify: Asian Indian 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Businessman Service Industry 4Yrs 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) If item 27 is marked Tulsi Makhija Khenchand G. Nichani 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kumar Nichani (Brother) 4601 Old Dragon Bath Ellicott City, Md. 21042. 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition Date 20c. Location - City or Town, State Baltimore, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 06/04/2011 Sykesville, Md. All County Cremation 4 Donation 5 Other Specify. 22. Name and Address of Facility 21. Signature Funeral Service Licensee Haight Funeral Home & Chapel P.O.Box 195 Sykesville, Md. 21784. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical UNPENDED AMENDED attending physician or use as the burial -Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of deliven 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Year Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ξ 1 Yes 2 No 3 Probably 4 V Unknown Completed of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has l performed? death? Yes 2 ✔ No 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other Nursing Home 5 Residence 6 Other: 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification 1 V Natural 1 Yes 2 No within 24 hours after death.

To the Funeral Director: Pending Director: __ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the

29b. Signature and title of certifie

Zabiullah Ali, M.D.

JUN 0 5 2012

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

and manner stated.

Assistant Medical Examiner

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

29d. Date signed (Month, Day, Year)

June 3, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Worth 2012 1529 M Medical Town, or Location of Death 4a. Facility Name (if not institution, give street and number, 4c. County of Death **Examiner** tou towar 6 Coreron a Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Hours Director 1 DM 2 3 21, 10c. City, Town or Location 10d. Inside City Limits at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director notified 28a-f s 1 les 2 No 100th 10e. Street and Numbe 10g. Citizen of What Country? ö be 23a 2 Completed by Funeral must l ral", or items 2 Examiner mus Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 Black 1 Yes 2 No Specify "natural", 3 ₩idowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than matic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ item 27 is marke other traumatic and l . Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Alexand)dom Holland 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State ŏ Important: If it any injury or o ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Full ral Service License 22. Name and Address of Facility 20794 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final gratio Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** 000 Jer 10 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine the Hospital or Attending Physician; The law requires that the death certificate be executed burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy ate has been signed by the atter page 2 should be detached for in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 Unknown a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has I autopsy death? 2 No 1 Yes 2 2 director, 25. Was case referred to cal examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital မ 1 🗌 Inpatient 2 🔀 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify, filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner eath 28c, Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred Natural injury 5 Pending 2 Accident
3 Suicide Investigation 24 hours after death Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause

Certifying Myras Practitioner is the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Funes

completely fi of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year)

JUN 0 5 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 8:44 AM **Physician** Jr Alexander OSC June 3 2012 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** Birthplace (State or Foreign Country) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) **Funeral** 1**X**] M 2 □ F January 16, 1943 MAryland 69 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland or 28a-f show notified at 10b. County 10a State Sparrows Point 1 ☐ Yes 2X No Baltimore Maryland Director 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number ö 21219 "natural", or Items 23a or dical Examiner must be 2622 Sparrows Point Road USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1★ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify Specify: White þ 3 Widowed 4 Divorced 16b. Kind of Business/Industry
Baltimore City Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Ith and Mental Hygiene.

27 is marked other than "r traumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) Police Department Police Sergeant 12 years vears 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Elizabeth Orzewicz Alexander Francis Orr Sr. မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2622 Sparrows Point Road, Sparrows Point, MD. 21219 nt of Health a : If item 27 is or other tra wife Mary Orr 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition June 8, 1 XBurial 2 Cremation 3 Removal from State Glen Burnie, MD. Department o Important: If any Injury or once. Glen Haven Cemetery 2012 4 ☐ Donation 5 ☐ Other (Specify) ature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part 1. Enter the disease (or complications that caused the death, shock, or heart failure. List only one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** (ardiac Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 1/ea-5 Failure Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed 01404 Due to (or as a consequence of): Arten attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death Month Year Day in the past 12 months? Pregnant at time of death 5 Other (specify) ed by the at detached f 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by failure heart 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2X No 2 **N**No 1 Tyes 1 Tes within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, t 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ★ ER/Outpatient 3 ☐ DOA Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) ၉ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 1 Natural 28b. Time of Certification: 5 Pending investigation Injury 1 _ Yes 2 _ No 2 ☐ Accident 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 3,2012 MO D0069427

State

Registrar

4940 Eastern Avenue, Baltimore, MD, 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

eham

JUN 0 5 2012

Kiemanh Pl 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11:28 AM Physician/ rien Ma 12 0/2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner timor izalieth a UNSINA enter 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** FEb 3 Months Days Hours Min. 1928 North Carolina Director 238-36-7104 84 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State with the Maryland Director 1 √ Yes 2 □ No Baltimore MD 10f. Zin Code 10g. Citizen of What Country? 10e, Street and Number Funeral USA 1035 DeSoto Road 21223 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ò 1 Never Married 2 X Married within 72 hours after Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. white "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 0 homemaker own home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Irene Mae Mangom Thomas Clyde Lloyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1035 DeSoto Road Baltimore, MD 21223 Carroll O'Brien/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State any injury or 4 X Donation 5 Other (Specify) Signatur of Funeral Service State Anatomy Board 655 W. Baltimore Street Director Raltimore. MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ nh disease or con Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): resulting in death) Last physician the burial Medical ension Box 68760 attending pl IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery Physician/ 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 9 Unknown Division of Vital Records, P.O. signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 2 X No 1 🗌 Yes 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No page 2 s prior to completion of cause of death? certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director; After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: X Natural 5 Pending 2 🗌 No 1 Yes Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of promining and/or inventioning the promining and the cause of promining and the cause o Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

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			Registrar 1. Decedent's Nam	e (First, Middle,	Last)		06/	incare	OIL	Calii		2. Date of De	Reg. No eath	o, L C	/ 1 6	<u> </u>	e of Death
	Physicia Medic		MOLLI		ILBAUM							JUNE	02	^{ay} 201	Year 2		00 A M
-	Examir	ner	4a. Facility Name (ii OAK CRE:		give street and numbe \GE	r)			Town, or	Location (of Death		40	County BA	of Death	ORE	
	Funeral Director		5. Social Security N 079-20- Usual Residence	8748		Age (In yrs. la	-	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di 06/28/	rth a <i>y</i> , Yea <i>r)</i> 1925			lace (Sta	te or Foreign
	ryland -f show ied at	ctor	10a. State	10b. County)DE	10c. City	y, Town or Loc		TI 1 F		l				1		e City Limits
	the Ma or 28a e notif	Funeral Director	10e. Street and Nu	BALTIM(JKE		P	10f. Zip					10g. C	itizen of W	/hat Coun		Yes 2 IAI No
	is 23a nust b	neral	8832 WA	LTHER BU	VD., APT.	118			212	234					USA		
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Fur	11. Marital Status 1 ☐ Never Mari 3 🄀 Widowed		12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Dates	\$? X I No	If		ify Cubar	n, Mexicar	, Puerto	ecify Yes or No- Rican, etc.)	-		- Americ k, White, e		,
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Maryland	should be filed within 72 n and Mental Hygiene. 7 is marked other than "r raumatic event, the Med	To Be	17. Father's Name (st) MERLING					18. Moth		e (First, Middle Zi	, Maiden ALEF)		
Man	12 should lith and N		19a. Informant's N		1 21 1		19b. Mailin 521 G	-				HERRY I	-				
Baltimore,	Page 1 and 2 snort of Health ant: If item 27 ary or other tra		20a. Method of Dis	position Cremation	B ☐ Removal from St	20b. P	lace of Dispor	sition (Nan	ne of	e)	Ī	Date	20c. L	ocation -	City or To	wn, State	
altin	permit. Page 1 Department of Important: If i any injury or o		4 ☐ Donation 21. Signature of Fu	5 Other (Sp		ME	22	. Name an	d Addres	s of Facilit	y SUL	/2012 LEVINS	SON	BR4	15.,	INC.	
8	e a = E		220 Tal Enter	202	omplications that cau	and the death						ROAD,		ESVIL	LE,		
	Pnysician, Medical		shock, or hea Immediate Cause disease or condition resulting in death)	rt failure. List on (Final	ly one cause on each	line.		r the mode	e or dying	g, such as	cardiac c	or respiratory a	rrest,			Approxir Interval I Onset ar	
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Вох	Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours alter death. Funeral Sifer death. Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Me	23b. Was decedent in the past 12 1 ☐ Yes 2 ↓ 9 ☐ Unknown	months?	23c. If yes, outcor 1 Live Bir 4 Pregnar 9 Unknow	th 2 □ Feta nt at time of d	il death 3 🗌	Ectopic p Other (sp		у				23d. Date Mor	e of delive	ery Day	Year
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Division of Vital Records,	I or Attendii after death. Director: At d in by the fu	Certificate:	2 Accident 3 Suicide 4 Homicide	Investiga 6 Could no determin	ot be 28e. Place of	Injury - At ho		M eet, factory		Yes 2 🗆	\rightarrow	28f. Location (r or Rural	Route Nu	ımber,
Ö	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in E		29a. Certifier	Certifying F	Physician: To the best			occurred at	the time	date and	place ar				er as state	-d	·
	the Ho hin 24 h the Fur npletely	Medical	(Check 2 only one) 3	Medical Ex	aminer: On the basis of lurse Practitioner: To	of examination	and/or invest	igation, in r death occu	my opinio urred at th	n, death oo ne time, da	curred at	the time, date	and place the cause	e, and due e(s) and m	to the cau anner as s	ise(s) and tated.	manner stated
	wit or or		29b. Signature and	title of certifier	0	_		29c	License					ite signed			. –
	Q_{j}		30. Name and addr	ess of person w	no completed cause of	of death (Item	23a) (Type, P	rint)	112	86	40			UNK		20	
	Sta	te.	Anna 31. Date filed (Mont		32. Regi	S-S O	o l	May 1	the	25	B	0/200	ري	Par	ku:1	1c, M	0 21231
	Registr		31. Date filed (Mont	2012	Zener &	rar's Signat	Mar										

6/2/2012 9:00 a.m.

Mollie Ohl bown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh g928 6-14-12 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 30, 2012 Year Gerald A. Otten 12:10_{pM} Medical 4a, Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Columbia Gilchrist Center - Howard County Howard 8. Date of Birth (Month, Day, Year) Oct 4, 1927 6. Sex If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Socia29-9-11116-116-16474 7. Age (In vrs. last birthday) If Under 1 Year Days Min. Hours 210.22.1636 84 MD Director 1 🛛 M 2 🗆 F Usual Residence of Decedent at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director ms 23a or 28a-f s must be notified MD Howard **Ellicott City** 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2530 Kensington Garden 102 21042 U.S.A. items permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian "natural", or itel dical Examiner Black, White, etc. Completed by 1 Never Married 2 Married Year or Dates. 3 - 12 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No White Specify: 3 → Widowed 4 □ Divorced -6-47 the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ed other than " Elementary/Secondary (0-12) College (1-4 or 5+) id Mental Hygiene. marked other tha Superintendant of Mails **Postal Service** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank Otten Nora Deutsch other traumatic and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12094 Windsor Moss Ellicott City, MD 21042 Michael Otten Son item 27 i 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date cemetery, crematory or other place)
Crest Lawn Memorial Gardens 1 Burial 2 Cremation 3 Removal from State Jun 04, 2012 Marriottsville, Maryland 4 Donation 5 Other (Specify) 22. Name Siack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 of Function Service Lice unelller M00535 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between nediate Cause (Final Onset and Death Ph_{sician} Motastatic sease or condition resulting in death) (ancer o e ke Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of). If any, leading to immediate cause. Enter Underlying Physician/Medical Exam Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) ul or Attending Physician: The law requires that the death certificate be after death.
Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ fibrillation Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown cate has been signated bage 2 should b Completed percatemia 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 No 2 No Yes funeral director, 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) 2V No Other: 1 Tes Hospice 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural $5 \square$ Pending work? injury 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical 29a. Certifier 1 'Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DS

31. Date filed (Month, Day, Year)

6336

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Timothy Frederick Pretty 1. Decedent's Name (First, Middle, Last) 3. Time of Death 230 A M Physician/ mo Medical 4a. Facility Name (If not institution, dive street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Season's Hospice Randallstown Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours 220-68-5750 Director 1 XM 2 □ F 55 05 57 28 MD 10b. County 10c. City, Town or Location 10d. Inside City Limits Director be notified 28a-f 1x Yes 2 □ No MD NA Baltimore 0 10e. Street and Number 10g. Citizen of What Country? Funeral <u>2619 North Hilton Street</u> 21216 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Yes Yes, Give 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: Specify: Black "natural" 3 🗆 Widowed 4 😾 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than matic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. 2th grade Self Employed Home Improvement Be 18. Mother's Name (First, Middle, Maiden Surname) 2 of Health and Menta fitem 27 is marked rother traumatic e Timothy Pretty Jr. Jeannette Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2619 North Hilton Street, Baltimore, Md 21216 Timothy Pretty Jr. Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Important: I any injury or 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 6/6/2012 Woodlawn, Signature of Funeral Service Licenses 22. Name and Address of Facility
March F/H West
4300 Wabash Av Baltimore 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 as the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an filled in by the funeral director, Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of • Hospital or Attending Pi 24 hours after death. • Funeral Director: After the Certificate: 28c. Injury at 28d. Describe how injury occurred Natural iniury 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) nd address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar BCB

31. Date filed (Month, Day, Year)

0 5 2012

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		1- For State Registrar		tificate of D		i wentan n		ے کے ل g. No.	112 1103
Physici Medical Exami	an/	1. Decedent's Name (First, Middle,Last	Polanous	ski _			2. Date of Death Month May 26, 20	n Day Year	3. Time of Death 2345 hrs
		4a. Facility Name (if not institution, given 7924 Diehlwood Road	e street and number)		City, Town, or L Oundalk	ocation of Death	1	4c. County of Baltimore	
Funeral Director		5. Social Security Number 6. Se	7. Age (In yrs, Ia		f Under 1 Year Months Days	If Under 24Hrs Hours Min	_ /		9. Birthplace (State or Foreign Country)
Maryland 28a-f show any d at once.	.or	Usual Residence of Decedent 10a. State 10b. County Dulh		Town or Location	K	<u> </u>	1707		10d. Inside City Limits 1 Yes 2 No
ı with the Maryland ms 23a or 28a-f sbo be notified at once.	Director	10e. Street and Number 7924 Dick	wood Road	1	of. Zip Code	2	10	g. Citizen of What	t Country?
r death	by Funeral	11. Marikal Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If Yes,	specify Cuban, I	anic Origin? (S Mexican, Puerto specify:	pecify Yes or No- Rican, etc.)	White,	American Indian, Black, etc.
C1 3 -	Completed t	15. Decedent's Education (Specify or Elementary/Secondary (0-12)		16a. Decedent's l during most		on (Give kind of on ON ON ON ON ON ON ON ON ON ON ON ON ON		16b. Kind of Busin	ness/Industry
	Be	17. Father's Name (First, Middle, Last)	Polanowski	4		Doro	Fluid (First, Middle, M	Kratz	
MD and 2 sho salth and 2 sin 27 is	To	19a. Informant's Name/Relationship (T	W.Ski-Nother	7924 Place of Disposition	Name of ceme	wood R	Rural Route Numi	per, City or Town, 100/K 20c. Location - C	State, Zip Code) N 2 12 12 City or Town, State
Baltimore, permit. Pages 1 a Department of He Important: If its injury or other in		1 Burial 2 Cremation 3 4 Donation 5 Other Specify: 21. Signature of Funeral Service Ocean	Da.	rematory or other 22. Name	And Address of	of Facility B	30/2012 ad ley -	Balhr	TONE MD
Physician /Medical		23a. Part I. Enter the disease, or compl failure. List only one cause on ea		Do not enter the n	node of dying, si	uch as cardiac o	or respiratory arre	st, shock, or heart	Between Onset and
Examiner			Stab Wound of Chest Due to (or as a consequence of):					Death
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence of						
executed an and al - transit		events resulting in death) Last d. UNPENDED	Due to (or as a consequence of) AMENDED). 					
	/Medi	IF FEMALE: 23b, Was decedent pregnant in the	23c. If yes, outcome of pregn		23d. Date of de	3d. Date of delivery Month Day Year			
Box 68760, te death certificate be execut the attending physician and red for use as the bunal - trai	Physician/Medica	past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at time of dea	2 Fetal of ther	eath 3(Specify)	Ectopic pregna		WOTE	Day Year
rds, P.O. requires that the been signed by the hould be detached.	2	Part II. Other significant conditions	contributing to death but not re	sulting in the unde	rlying cause giv	en in Part I.		pacco use contribu	te to the cause of death? Probably 4 Unknown
2 s	Completed					· - · · ·	24a. Was a autops perform	y prid ned? dea	ere autopsy findings available or to completion of cause of ath? Yes 2 No
/ital sician: is certii lirector	Be	25. Was case referred to medical examiner?	ospital: 1 Inpatient 2	ER/Outpatient 3		of Death (Check		Residence 6	Other: Scene
on of Vital Rec nding Physician: The th. r: After this certificate in funeral director, page	ion: To	1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year) May 26, 2012	28b. Time of Injury	/ 28c. Injury			ow injury occurred	
Division of Vital Rec To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined.	28e. Place of Injury - At ho		actory, office bui	ilding, etc.		reet and Number ate) d Road, Dunda	or Rural Route Number, City
To the Hosp within 24 ho To the Fune	Medical C	29a. Certifier 1 CertifyIng Physicle (Check only one) 2 Medical Examiner	an: To the best of my knowledg On the basis of examination an and manner stated.	e, death occurred id/or investigation,	at the time, date in my opinion, o	e and place, and death occurred a	due to the cause at the time, date a	(s) and manner a nd place, and due	s stated e to the cause(s)
F 3 F 3	Me	29b. Signature and title of certifier	11-3002-7		29c. License			29d. Date signed May 27, 201	(Month, Day, Year) 2
14		30. Name and address of person who o	ompleted cause of death (Item 2 Assistant Medical Exam		Baltimore S	Street, Baltin	nore, MD 212	223	
Si	ate	31. Date filed (Month, Day, Year)	2. Registrar's Signatur	e be New	,				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ DWE 221 Ju Medical 4a. Facility Name (if not institution, give street and numb Examiner 4b. City. Town, or Location of Death <u>628 N. Eutaw Street #202</u> Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Міг **Director** 218-64-0687 1 X M 2 🗆 F Yrs Usual Residence of Decede 62 Mar 26, 1950 Maryland item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" any injury or other traumant. 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 628 N. Eutaw Street #202 21201 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, White, etc.
African Armed Forces 1 X Never Married 2 Married Yes 2 X No 1 Yes 2 No Specify If Yes, Give 3 Widowed 4 Divorced Year or Dates American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Welder Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Calvin J. Powell Omgea Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 628 N. Eutaw St. #202 Baltimore, MD 21201 Marie Malory / fiancé 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Final Journey Crematory 6/7/2012 Woodbine, Maryland Signature of Funeral Service of en Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ea Immediate Cause (Final Onset and Death Physician/ ancek disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed ause (DiSease Or Hijury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE Ise 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ó Month Day Year Pregnant at time of death ed by the a 9 Unknown 9 Unknown signed to d be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 70 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy perform 2 🗌 No __ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA this 5 Residence 28a. Date of injury (Month, Day, Year) 27. Mann of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury **▶** Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation after death Director: / 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

within 24 hour To the Fune completely fi

24 hours a Funeral I

State

Registrar

Medical

29a. Certifier

(Check only one)

31. Date filed (Month, Day, Year) 32. Registrar's 5 2012

(Item 23a) (Type

Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DHILLIPS 2012 ANNE MA-Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HOSE ITAL MEDSTAR HARBOR BALTIMORE Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 214-38-4610 1 □ M 2 🔀 F Director Sept 14, 1934 77 28a-f show 10c. City, Town or Location 10d. Inside City Limits aţ Director must be notified 1 Yes 2 No MD Baltimore 5 10e, Street and Number 10f. Zip Code 10a. Citizen of What Country? "natural", or items 23a Funeral 21225 USA 216 Elizabeth Avenue death \ unk 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 💢 No Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. black Specify. 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than College (1-4 or 5+) Elementary/Secondary (0-12) should be filed with and Mental Hygien is marked other th unk unk unk Be unk 7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra Habar Hospital 3001 S. Hanover Street Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🕅 Other (Specify) in state Truneral Serv State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ Acute Hypoxic Resp disease or condition resulting in death) Medical 35 days **Examiner** Sequentiary first conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events requires that the death certificate be executed Exam NSTEMI Due to (or as a consequence of) resulting in death) Last burialphysician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 X No the Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an PROTEUS UTE has autopsy performed? death? 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 ☐ Yes 2 X No 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide injury work 5 Pendina 1 Tyes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P. Calyhai warayen M.D. (HOSPITALIST) D 70674 MAY 2012

State Registrar W.D.

3001 S. HANOVER Street

Bullimore

21225

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAKSHMI N POTAKAMVRI,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 1:40 AM Coakley Pellegrino May Medical Clementine 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bethesda 9707 Old Georgetown Road, Apt. #1208 Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗌 M 2 🕱 Months Davs Hours Min 085-18-9987 91 October 31, 1920 New York **Director** Usual Residence of Decedent shov 10a. State 10c. City. Town or Location must be notified at 10d. Inside City Limits Director 28a-f 1 🗆 Yes 2 🗶 No Montgomery Bethesda Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 9707 Old Georgetown Road, Apt. #1208 20814 United States death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give ò <u></u> 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: White Year or Dates it of Health and Mental Hygiene.
If item 27 is marked other than "natur or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) University Research Librarian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Flora Williams Thomas Coakley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9707 Old Georgetown Road, Apt. #1208, Bethesda, Maryland 20814 Edmund Pellegrino / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of June 4, 2012 20c. Location - City or Town, State Department of H Important; If ite any injury or ot 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) St. Gabriel's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Potomac, Maryland Robert A. Pumphrey Funeral Home/Bethesda-Cheyy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 21. Signature of Funer Service Ligenses M01305 23a. Part ti. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician Pancreatic Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or i that initiated events -tran and Due to (or as a consequence of): resulting in death) Last burial physician s the burial Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) Day Year Pregnant at time of death g Unknown g Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed Hospital or Attending Physician: The this certificate 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🔲 Yes 2 💢 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of s after death. Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide М Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

le

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gary B. Wilks, MD

31. Date filed (Month; Day, Year)

D55258

7758 Wisconsin Avenue, #211, Bethesda, Maryland 20814

May 30, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 30^{Da}2012 Year SARAH PAZGAN MAY 4:10 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 183-34-0034 1 □ M 2 🛣 F 88 **Director** March 9, 1924 Poland Usual Residence of Decedent 28a-f shov within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Tes 2X No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? Funeral 21704 2817 Roderick Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner r 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed $3\mathbf{X}$ Widowed $4\square$ Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jozefa Zielnashik Kazimierz Cedzynski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2817 Roderick Road, Frederick, Maryland 21704 Jennie Drabick / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Montgomery Crematorium, Inc. 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State June 2, 2012 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc 7557 Wisconsin Avenue, Bethesda, Maryland 20814 Signature of Funeyal Ser M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician perkelemia Hours disease or condition Medical resulting in death) Examiner Ren Hom Sequentially list conditions Physician/Medical Examiner if any leading to immediate cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events burial-trar and Due to (or as a consequence of): resulting in death) Last attending physician Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No Yes 1 ∐ Yes 2 I 9 □ Unknown the Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? has page 2 this certificate funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of After t 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 2 Accident
3 Suicide
4 Homicide within 24 hours after deal To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D4309 5-31-12

Registrar
DHMH 17 Rev 06-2011

State

TOIL

801

Frederick

MD 21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Caidi Min

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Catonsville Catonsville Commons / Genesis Eldercare **Baltimore** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**∑**M 2□ F 93 Yrs. 403.36.0430 KY **Director** Jun 17, 1918 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant; If item 27 Is marked other than "natural", or Items 23a or 28a-f show Injury or other traumatic event, the Medical Examination must be positived as 1 Yes 2 No Directo MD Howard **Ellicott City** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4983 Threshfield Court 21043 U.S.A Funeral 12. Was Decedent Ever in U.S. Anged Forces? 1 Myes 2 No If Yes, Give 5.28.43 Year or Dates: 8.17-45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No White \$ Specify: 3 ☐Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Superintendent Polyethylene plant permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 Is marked oth any Injury or other traumatic Avant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be C. N. Phillips Priscilla Brothers ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan Phillips 4983 Threshfield Court Ellicott City, MD 21043 son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Jun 06, 2012 **Evergreen Cemetery** Greenville, KY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 Signature of Funeral Service Licensee Part 1. Then the diseal to or complications that consend the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician resulting in death) /Medical Due l r as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Director (or as a consequence of) Examir the Hospital or Attending Physician; The law requires that the death certificate be executed as the burial-tran and Due to (or as a consequence of): signed by the attending physician Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ρ in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death <u>6</u> 1 ☐ Yes 2 🗌 No 3 Probably Completed Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has page 2 After this certificate 2 No 1 □ Yes Be 25. Was case referred to medical examiner? 26. Place Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Mann Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 Pending n 24 hours are:
.he Funeral Director: A 1 ☐ Yes 2 ☐ No Accident investigation 2 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Within 2 29b. Signature and title of certifier

Hrigh

State Registrar lame and address of

31. Date filed (Month, Day, Year,

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ationBlvd Glan Burnie MD 2106

12-04053	
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Robert James Peterson

Please Type or Print in Black Indelible ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene

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(ODON GUMGO / GIO	1- For State Registrar	Cert	ificate of Death	ina manaa mygiama	Reg. No.				
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last)	Robert Jame	s Peterson	2. Date of Month May 2		3. Time of Death 1954 hrs			
j	4a. Facility Name (if not institution, give 301 McMechen Street #23	street and number)	4b. City, Town, 6 Baltimore	or Location of Death	4c. County of D	eath			
Funeral Director	5. Social Security Number 6. Sex 214–44–5095	7. Age (In yrs. las	st birthday) If Under 1 Ye Months Da			irth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Maryland			
Aaryland 28a-f show any Latonce. ector	Usual Residence of Decedent 10a. State MD	10c. City, 1	own or Location Bal	timore		10d. Inside City Limits 1 🖾 Yes 2 🗌 No			
th the Maryland 23a or 28a-f sho notified at once.	10e. Street and Number 301 McMechen St	reet #523	10f. Zip Code 2	1217	10g. Citizen of What (Country?			
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. tem 27 is marked ather than "natural", ar items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 X Divorced	or Dates:	If Yes, specify Cub		c.) White, et	lack			
5-0036 ed within 72 hours tygiene. inther than "natur the Medical Exam Completed 1	15. Decedent's Education (Specify only Elementary/Secondary (0-12) 8th	y highest grade completed) College (1-4 or 5+)	16a. Decedent's Usual Occup during most of working li Carpe	fe. DO NOT use retired)		mprovement			
21215-0036 uld be filed within 72 he Mental Hygiene. marked ather than "n; e event, the Medical E.	17. Father's Name (First, Middle, Last) Samuel Peter	son	· · · · · · · · · · · · · · · · · · ·	18.Mother's Name (First, Mi	ddle, Maiden Surname) Le Dukes				
MD 2121. nd 2 should be fit atth and Mental I m 27 is marked aumatic event, To Be	19a. Informant's Name/Relationship (Ty Anthony Peterso:	te Number, City or Town, S Llstown, MD 2							
2 E E E	20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other Specify:	Domougl from State Cr	ace of Disposition (Name of cematory or other place) unt Carmel Cer	emetery, Date	20c. Location - City	y or Town, State			
Baltimo permit. Page Department o Important: injury or ott	21. Signature of Funeral Service Licens	A. Weatherfo							
Physician /Medical	23a. Part I. Enter the disease, or complifications. List only one cause on each	Approximate Interval Between Onset and Death							
Examiner	or condition resulting in death)	Atheroscleroticule to (or as a consequence of)		tar Disease					
red nsit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	if any, leading to immediate Cause. Enter Underlying Cause Cuisease or injury that initiated C.							
60, cate be executed physician and he burial - transit Medical Exa	d.	ue to (or as a consequence of)	<u></u> -		į.				
60, ate be execu hysician an te burial - tr	X UNPENDED	AMENDED 23a , pt . I		930 8-29-12 sm	23d. Date of deli	hon			
). Box 6876 the death certificat the death certificat oy the attending phy ched for use as the Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Month	Day Year						
P.O. BOX		9 Unknown contributing to death but not res	sulting in the underlying cause	e given in Part I. 23e.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknow				
Division of Vital Records, P.O. Box 68760, To the Bospital artending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial—trans edical Certification: To Be Completed by Physician/Medical E	Drug Use			24a.	Was an 24b. Wer	e autopsy findings available to completion of cause of			
tal Reccian: The certificate ector, page	25. Was case referred to medical		26 Pla	1ce of Death (Check only one)	Yes 2 No 1	Yes 2 No			
Vital ysician ysician director		ospital: 1 Inpatient 2 E	ER/Outpatient 3 DOA	Other4 Nursing Home	5 Residence 6 🗸 C	Other: Scene			
on of vending Pheath. or: After the funeral	27 Manner of Death	(Month, Day,Year)	28b. Time of Injury 28c. In	jury at Work? 28d. Des Yes 2 No	scribe how injury occurred				
Division o spital in Attending tours after death. neral Director: After filled in by the fune Certification:	2 Accident Investigatio 3 Suicide 6 Could not b 4 Homicide	28e Place of Injury - At hor	me, farm, street, factory, office		ation (Street and Number o own, State)	r Rural Route Number, City			
Division To the Boppital ar Attent within 24 hours after death To the Funeral Director: completely filled in by the Medical Certification	29a. Certifier Certifying Physicia cone Certifying Physicia Certifying Physicia Certifying Physicia Certifying Physicia Certifier Certifying Physicia Certifier Certifying Physicia Certifier Certifying Physicia Certifier Certifier Certifying Physicia Certifier in: To the best of my knowledge On the basis of examination an								
F 3 F 3	29b. Signature and title of certifier			nse number	29d. Date signed				
Spend	30. Name and address of person who co		23a)	C.M.E. OCME	May 29, 2012				
	Theodore M. King, Jr., MD. 31. Date filed (Month, Day, Year)	Assistant Medical Ex	xaminer 900 W. Balt	imore Street, Baltimore	э, MD 21223 ——————				
State Registra	11 11 A W 774	2 Beneva B	. parle						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical MIT 2012 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death County of Death Baltimore ubspinaton Medical Anne Burnie Gles If Under 24 Hrs 8. Date of Birth Sept. 21 **Funeral** 1 **X** M 2 □ F Hours 213-30-5027 ^{∍ar)}193<u>4</u> Country) 77 Director MD Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2X No Anne Arundel Glen Burnie Maryland 10e. Street and Numbe 10f. Zip Code 5 10g. Citizen of What Country? Funeral 23a 21060 1135 Cedarcliff Drive USA or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 White 1 Yes 2 XNo Specify. Yes, Give "natural", 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Manager Bethlehem Steel 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Polczynski Helen Sadowsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important: If item 27 is any injury or other trau Audrey M. Polczynski 1135 Cedarcliff Drive, Glen Burnie, MD 21060 (spouse) altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1 XBurial 2 Cremation 3 Removal from State May 4 Donation 5 Other (Specify) Lakemont Cemetery Davidsonville, Maryland 2012 Signature of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home, P.A. Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ つしから disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine If any leading to immedia cause. Enter Underlying Cause (Disease or iinjury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical CHPHALOPAY Box 68760 IF FEMALE s, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year signed by the a 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed Yes Division of Vital the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death. Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work 1 Tes 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier completed (Check only one Certifying Nurse Practioner: To the best of my knowledge, de ath occurred at the time, date and place, and due to 29b. Signature and title of certifier 103 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WASHIN ULUJI LITE 31. Date filed (Mo State Registrar

DHMH 17 Rev 7/2009

DHMH 17 Rev 1/2001 OCME 2006

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State

Registrar

900 W. Baltimore Street, Baltimore, MD 21223

OCME

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Registrar's Signature

Russell Alexander MD.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ 2012 May 27, Lillian A. Riley 6:50 AM M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth Months (Month, Day, Year) Days Hours Director 215-16-6819 89 1 M 2 X F Jan 7, 1923 Maryland 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Medical Examiner must be notified 1 🗌 Yes 2 🙀 No Harford Forest Hill 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 1 Colgate Drive #516 21050 USA "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force þ Black, White, etc. 1 X Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Completed 3 Widowed 4 Divorced Specify: white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 11 secretary General Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Garfield Riley Elvira Serra 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Fischbeck/nephew 534 Counterpoint Circle Havre de Grace, MD 21078 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once, Date . Page 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 X Donation 5 Other (Specify) r Euneral Service I cen ²² Name and Address of Facility Board 655 W. Baltimore Street Baltimore, MD 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final disease or condition Preumonia Physician disease or codition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: for use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 2 No the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After (Month, Day, Year) Natural $5 \square$ Pending 1 Yes 2 No Accident Investigation Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the first of my in manage death occurred at the time out and place and dual to the cause(s) and name as stated. 29a. Certifier 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Gral 27-10 066 136 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UPPE 31. Date filed (Month, Day, Year) 5 2012 Registrar

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		for State	State of Ma	ryland /		rtment of H		Mental Hyg	_ / U	2 17705		
		Registrar 1. Decedent's Name (First, Middle, Last)			Cei	inicate or i	Death	2. Date of Deat		3. Time of Death		
Physici	_		RAINES					Month 05	าซี 20ำ	2 10:02 AM		
/Medio		4a. Facility Name (If not institution, give str	eet and number)			4b. City, Town, or	Location of Dea	h	4c. County of De			
		Moran Manor				Western	-		Allegar			
Funeral Director		5. Social Security Number 6. Sex 1 XN	7. Age	e (In yrs. last i	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year) (irthplace (State or Foreign Country) verton, WV		
pui		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Loc	cation	-			10d. Inside City Limits		
Maryla -f shov fied at	tor	MD Allegany		Wester	rnpor	rt				1 XYes 2 □ No		
If I I I I I I I I I I I I I I I I I I	al Director	10e. Street and Number 25701 SHady Lane So	outhwest			10f. Zip Code 21562		1	0g. Citizen of What USA	Country?		
fter death r items 2 ilner mu	Funeral	11. Marital Status 12 1 Never Married 2 Married	Was Decedent E Armed Forces? 1 ☐ Yes 2 【※ If Yes, Give					Specify Yes or No- rto Rican, etc.)	Black, W			
ours a	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🛣 No				White		
"natu	Completed	15. Decedent's Educa (Specify only highest grade)	tion completed)	10	(Give	lent's Usual Occup kind of work done DO NOT use retire	during most of we	orking	16b. Kind of Busines Pendletor	,		
withir liene.	ошо	Elementary/Secondary (0-12)	College (1-4or 5	i+)		ol Teach	-		Schools			
	To Be C	17. Father's Name (First, Middle, Last) Ora M. Raines						me (First, Middle, nompson R				
and 2 should be ealth and Mental n 27 Is marked oner traumatic ever	-	19a. Informant's Name/Relationship (Type Dewayne Raines - No	, City or Town, State, Zip Code) Lon, VA 22625									
Defiliniore, IN permit. Pages 1 and 2 Department of Health Important: If item 27 I any injury or other tra		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🔭 Re	moval from State	20b. Place	e of Dispo etery, crer	sition (Name of matory or other pla	ce)	Date	20c. Location - City	or Town, State		
Pages ment of Hant: If ite		4 ☐ Donation 5 ☐ Other (Specify)		N. F		Memorial			Riverton,	WV		
partillion permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Salice Licenses	MODS			2. Name and Addre		tome- =	B 215 ranklin, b	W 21.5617		
		23a Part1. Enter the disease, or complic	ations that caused	the death. D						Approximate Interval Between		
Physician		shock, or heart failure. List only one Immediate Cause (Final disease or condition	cause on each iii	ne.		Arly				Onset and Death		
/Medical	ı	resulting in death)	Due to (or as		ce of):	7				y		
Examiner	je	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequen	ce of):							
ecuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to /or on	(or as a consequence of):								
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ertifica		IF FEMALE:	c. If yes, outcome	of pregnance	,	-			23d. Date of	dolivon		
cords, F.O. BOX bofou, w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth 4□Pregnant a 9□Unknown	2 Fetal de	ath 3	⊒Ectopic pregnand ☑ Other <i>(sp</i> ec <i>ify)</i> _	су		Month	Day Year		
that the hed by	by Ph	Part II. Other significant conditions conf	ributing to death b			inderlying cause gi	ven in Part I.	23e. Did to	obacco use contribut	e to the cause of death?		
cords v requires been sign should be	ed b	_ Endstry	Mine	Or Se	~	, ly pe	rtjeder	10	/es 2 No 3 □	Probably 4 Unknown		
tec e law has b	ompleted							24a. Was - autor perfo 1 Yes				
VITAL IN SICIAN: The sector, pag	Be C	25. Was case referred to medical examiner?					the ext	eath (Check only o				
this dia	은	1 Yes 2 No	ospital: 1 ☐ Inpati	ent 2 ☐ ER	Outpatie b. Time o	III 3 DOA			dence 6 Other (Specify)		
ding Affer fune	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Da		Injury		ork?]Yes 2.∏No					
irec irec	Certification:	3 Suicide 6 Could not be determined		jury - At home tc. (Specify)	e, farm, st	reet, factory, office		28f. Location (City or To	Street and Number o vn, State)	r Rural Route Number,		
To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best er: On the basis of and manner st	of examination	edge, dea n and/or i	th occurred at the nvestigation, in my	time, date and pla opinion, death o	ace, and due to the courred at the time,	cause(s) and manne date and place, and	er as stated. due to the cause(s)		
To the within To the	Me	29b. Signature and title of certifier		<u> </u>		29c. Licer	ise number		29d. Date signed (M	fonth, Day, Year)		
		I was	\sim 1			23	1244		1/22/20	012		
1 60		30. Name and address of person who con	mpleted cause of	death (Item 2	3a) (Type	, Print)						

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State Registrar

DHMH 17 Rev 1/2001

Dr. Jesus Tan - 4 S Broadway
31. Date filed (Month, Day, Year)

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 201 2 May 31 12:00pm **GEORGE** REISNER Medical la. Facility Name (if not institution, give street and number)
Greater Baltimore Medical Center Town, or Location of Death **Towson** Examiner 4c. County of Death
Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Hours (Month, Day, Year) 121-07-8021 Director 1**X**] M 2 □ F Yrs. 94 03/08/1918 NY 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No PALM BEACH PALM BEACH permit. Page 1 and 2 should be filed within 72 hours after death with the I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examiner must be no one. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2295 SOUTH OCEAN BLVD., #607 USA 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 XNo Specify: If Yes, Give Specify 3 X Widowed 4 Divorced Year or Dates WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) OWNER MEN'S CLOTHING STORE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ **JACOB** REISNER MINNIE CHANOWITZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUDITH LEVY/DAUGHTER 152 CHRISTIAN AVENUE STONY BROOK, NY 11790 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
ETERNAL LIGHT
MEMORIAL GARDENS 1 X Burial 2 Cremation 3 X Removal from State Donation 5 D Other (Specify) 06/01/2012 BOYNTON BEACH, FL 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. ichal 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Gospon teso Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Box 68760 Cod that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be execuithin 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician an resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Other (specify) Month Dav Year Pregnant at time of death ed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 100 ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural
2 Accider iniury 5 Pending Accident Investigation Suicide 6 🗌 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar 29b. Signature and title of certific

31. Date filed (Month, Day, Year)
JUN 0 5 2012

N.

John 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chades

29d. Date signed (Month, Day, Year)

21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Edmund John Vernon Rosenberger, Jr. Month 4:26 PM 2012 JUNIO Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SAINT JOSEPH BALTIMOR SOR **Funeral** Birthplace (State or Foreign Country) 8. Date of Birth Months (Month, Day, Year) 212-44-3002 **Director** 1 ▼ M 2 □ F 68 May 23,1944 Maryland 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at with the Maryland Director BENBERCER, EDMOND JOHN Maryland Baltimore Cockeysville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1032 Saxonhill Drive 21030 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. ò, 2 1 Never Married 2 X Married 1 X Yes If Yes, Give 2 No 1969-Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", 3 Widowed 4 Divorced White Completed 1970 Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than filed within all Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the High School Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Important: If item 27 is marked any injury or other traumatic evence. Edmund John Vernon Rosenberger, Sr. Evelyn Dorothy Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Rosenberger/Wife 1032 Saxonhill Dr., Cockeysville, Maryland 21030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. | 06/04/2012 | Baltimore, Maryland Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland Inc 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) sician and burial-tran resulting in death) Last Due to (or as a consequence of the attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 XN this certificate 1 Yes 2 No Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 X No 1 Inpatient 2 KER/Outpatient 3 IDDA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Director: After 1 🔀 Natural 5 Pending injury Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1601 OSLER DRIVE TOWSON, MARYLAND 21204 JAMES M. WILLIAMS 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month O5 Physician/ PATRICIA REDFERN 6:20 A.M Medical 2012 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE WASHINGTON MEDICAL CEMER GLEN BURNIE ANNE ARUNDEL Social Security Number **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Iowa Towa Director 523-46-3514 73 1 M 2 W or 28a-f show 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Prince Georges 1 🗆 Yes 2 🔀 No Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15745 Haynes Road 20707 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. "natural", or Š 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 X Divorced Specify: white Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Callege (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other the any Injury or other traumatic event, the I Executive Assistant RAP, Inc. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Hamilton Clark, II Mary Louise Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Redfern / son 7513 Saffron Court Hanover, Maryland 21076 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Metro Crematory, Inc. 06/01/2012 | Baltimore, Maryland 21. Signature of Furural Service LicenseeStephanie Custer 22. Name and Address of Facilit Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MEART CONGESTIVE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last To Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day 1 ☐ Yes ∠ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERTENSION Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown CHRONIC KIDNEY DISEASE 24a. Was an 24b. Were autopsy findings available autonsv prior to completion of cause of death? perform Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. TARAK REDDY, MO

Registrar DHMH 17 Rev 06-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D69090

301 HOSPITAL DRIVE, GLEN BURNIE, MD.

29d. Date signed (Month, Day, Year)

2012

05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death FOR PM Physician/ = SSLE 2012 a Medical 4a. Facility Name (if not institution, give street and number Examiner 4c. County of Death Baltimore Randallstown Seasons Hospice Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Director 218-28-5277 1 **X** M 2 □ F 82 12/4/1929 Maryland Usual Residence of Deced show 10b. County at 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified Catonsville Baltimore Maryland 1 Tes 2 X No 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21228 United States 1 Bristol Hill Court Condo A-2 tems Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 X Yes 2 □ No Black, White, etc 1 Never Married 2 Narried X Yes Baltimore, Maryland 21215-0036 Specify: caucasian 1 ☐ Yes 2X No Specify. If Yes, Give 3 Divorced Year or Dates f Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Blind Industry 12 Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles F. Roessler, Jr. Mary Ann, Taafe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bristol Hill Court A-2, Catonsville, MD 21228 Elizabeth L. Roessler/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Meadowridge Memorial | 06/02/2012 Elkridge, Maryland 21. Signature of Funer Solvice Lic 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final ATherosci Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially hat conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physician detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) Pregnant at time of death g Unknown 9 Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy after death.

Director: After this certificate Yes 2 filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital မ 1 🔲 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred injury Natural 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifier ss of person who completed cause of death (Item 23a) (Type, F ax11

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Physician/ Forb Scott 2:54 AM 2013 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore sanklin 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) 407 52 5244 **Director** 1 🛎 M 2 🗆 F 74 Feb.26,1938 Kentucky or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director Maryland Baltimore 1 🗌 Yes 2 🄀 No Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 421 Riverside Dr. 21221 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin one. 1 Never Married 2 Narried þ 21215-0036 White 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Clergy Religion Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ben Scott Nancy Ball 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace Scott (Wife) 421 Riverside Dr. Baltimore, Maryland 21221 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gardens 6/8/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licer ^{22. Name and Address of Facility} Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, W. fait 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bock, or heart failure. List only one cause on each line. Interval Between Onset and Death Ph. sician/ disease or condition a. ATHEROSCLE ROTIC CARDIOVASCULAR HEART DISEASES Medical resulting in death) Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performe 1 Yes 2 No Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 ☑ No Hospital Other: 2 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after deau.

To the Funeral Director, After the Funeral Directory of the funer that the funer that the funer that the funer that the funeral Directory of t Matural injury 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. June DO056092 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive Baltimore Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-03964 State of Maryland / Department of Health and Mental Hygiene Patricia Stansburge Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day May 25, 2012 Modical Examiner Patricia Anne Stansburge 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and numbe 3814 Memory Lane Apt C Abingdon 5. Social Security Number 6. Sex **Funeral** Months Days Hours Director Nov. 15, 214-40-2277 1 M 2 XF Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location s 23a nr 28a-f show e notified at once. Abingdon Maryland Harford Figure 1 MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
The filem 27 is marked other and the file of the fil Director 10e. Street and Number 10f. Zip Code USA 3841 Memory Lane Apt. C 21009 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married Yes 2 X No 1 Yes 2 No specify: If Yes, Give Year 4 Divorced ò 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Administrative Assistant 17. Father's Name (First, Middle, Last) Be Edward Dale Workley 19a. Informant's Name/Relationship (Type, Print) Robin Anderson / Daughter 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State 5-31-2012 Rose Hill Svcs, LLC Donation 5 Other Specify 22. Name and Address of Facility Signature of 3a Part I Enter the disease, or **Physician** failure. List only one cause on each line Medical a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate eause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last e attending physician and for use as the burial - transit AMENDED #4a, per me, g928 6-5-12 sm Physician/Medical UNPENDED Records, P.O. Box 68760, The law requires that the death certificate be-IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown certificate has been signed by the sector, page 2 should be detached for Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ Completed 24a. Was an autopsy page Yes 2 ✔ No 26.Place of Death (Check only one) 25. Was case referred to medical æ examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this 1 🗸 Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 1 V Natural 1 Yes 2 No Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide

4c. Counfy of Death Harford If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Country) Maryland 1941 10d. Inside City Limits 1 Yes 2 X No 10g. Citizen of What Country? 14. Race - American Indian, Black, White, etc. White Specify: 16b. Kind of Business/Industry Automotive 18. Mother's Name (First, Middle, Maiden Surname) Madeline Rose Memmel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 604 Priestford Road, Churchville, Maryland 21028 20c. Location - City or Town, State Bel Air, Maryland McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death 23d. Date of delivery Year Month Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes Hospital or Attending Physician: Other; Nursing Home 5 Residence 6 🗹 Other: Scene 28d. Describe how injury occurred Division after death.

| Director: / d in by the fi 28f. Location (Street and Number or Rural Route Number, City determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number May 27, 2012 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Assistant Medical Examiner Russell Alexander MD 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar **OCME**

2012

3. Time of Death

0058 hrs

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 2:30 PM Edna Scott Medical June 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Stella Maris Hospice Lutherville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min **Director** 88 1 M 2 1 219-18-4034 Yrs May 02, 1924 North Carolina Usual Residence of Decedent or then "netural", or items 23e or 28e-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 201 N. Washington St. Apt. 21231 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 🖼 No Specify: Completed 3 Widowed 4 ☐ Divorced Specify: Year or Dates Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Kings Seely Thermos Elementary/Secondary (0-12) College (1-4 or 5+) 10 Assembly Line Worker Division Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mentel ည Scott Carthern Bertha Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Importent: If Item 27 is any Injury or any Sylvester Kane /Son 31 Holly Dr. Hatboro, PA 19040 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Jun 05 4 Donation 5 Other (Specify) Beltsville, Maryland Chesapeake Crematory 2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 10 Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) METASTATIC CANCER UNKNOWN PRIMARY Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): ed by the attending physicien detached for use es the burla Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 X No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death 9 Unknown Records, P.O. ate has been signed by pege 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' this certificate 1 ☐ Yes 2 ☐ No Yes 2 X No director, **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) HOSPICE 1 ☐ Yes 2 👿 No |2 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funerel Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident
Suicide 1 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one 29b. Signature and 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, **CRNP** 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State

Registrar

31. Date filed (Month, Day, Year,

JUN 0 5 2012

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 57 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death more Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Mar 31, 9. Birthplace (State or Foreign **Funeral** Hours Min 60 **Director** 214-58-7265 1 XM 2 🗆 F 1952 Maryland 28a-f shov 10a, State 10c. City, Town or Location must be notified at Director 10d. Inside City Limits 1 Yes 2 No Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21221 303 Maple Ave. Apt. United States "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian the Medical Examiner 1 Never Married 2 Married Black, White, etc. ģ ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 24 No Specify: 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 10 Truck Driver Carl's Messenger injury or other traumatic event, Be Shepard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Edward Shepard Sr. Doris Mae Russell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Janis Shepard /Wife 303 Maple Ave. Apt. A Essex, MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Jun 02 4 Donation 5 Other (Specify) Chesapeake Crematory 2012 Beltsville, Maryland Signature of Funeral Service Licensee 22. Nacremation Family Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy that the death for in the past 12 months? Month Pregnant at time of death Other (specify) Day Year Yes 2 No the Unknown 9 Unknown P.O. β Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 : Jas autopsy 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 \(\text{Yes} 2 M No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes Certificate: 28b. Time of 28d. Describe how injury occurred eral Director: After filled in by the funer 1 Natural 5 Pending injury 2 🗌 No Investigation 6 Could not be Accident 3 Suicide
4 Homicide Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours after To the Funeral Direc Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5000C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Square Drive Boltimore MD 31. Date filed (Month, Day, Year)
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Registrar

John

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Medical Exam	inei	THE BUILT OTAL	a Skahill					Month May 19	-	Year	1225 hrs
		4a. Facility Name (if not instituti 303 Bayside Drive	on, give street and n	umber)	46	Dundalk	ocation of Dea	ath	4c. County of Death Baltimore County		
Funera		5. Social Security Number	6. Sex	7. Age (In yrs. last birtho	day)	If Under 1 Year	If Under 24H		Birth(MM		. Birthplace (State or
Director		220-36-2047	1 M 2 XF	73	Yrs.	Months Days	Hours M	in. Mar	5, 19		oreign Country) Mary Land
any	1	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location						10d. Inside City Limits
- A	١.	,	imore		dalk						1 Yes 2 No
arylan 8a-f sl	Director	10e. Street and Number		Del		10f. Zip Code			10g. Cit	izen of What (71
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Dire	303 Bayside D	rive			2122	22		USA		
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Baltimore, MD semit. Pages 1 and 2 sho Oppartment of Health and Important: Uitem 27 in injury or other traumati		21. Signature of Euneral Survice	S. Wade	irector	22 Nar Sta	ne and Address of te Anato	Facility Omy Boa	rd 655	W. E		re Street
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Box 68760, e death certificate be the attending physic ed for use as the bur	Physician/Medica	1 Yes 2 No 9 Uni	,	ant at time of death 5	Other	(Specify)					
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Division Hospital or Attend 24 hours after death Funeral Director:	Certification:	4 Homicide deter	mined (Specify)					or Town,			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example 1	niner:On the basis of	t of my knowledge, death of examination and/or inve	occurred	et the time, date :	and place, and eath occurred a	d due to the car at the time, dat	use(s) and	d manner as st	ated. the cause(s)
To viii	Me	29b. Signature and title of certifie	and manner st	ated.		29c. License no	umber		29d. D	ate signed (A	Month, Day, Year)
		1 whole	ma)			O.C.M.E	E.		May	20, 2012	
	1	30. Name and address of person									
		Laron Locke MD. As		Examiner 900 W	/. Baltii	more Street, E	Baltimore, I	MD 21223			

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Registrar

/	Lia da a	Canada
Kenneth	marian	2110012

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enneth Harlan Sno		State of	Maryland /	Department of Health and Men	tal Hygiene	201	2 1771
	1- For State Registrar			Certificate of Death	Reg. N	0.	La I I I I
Physician/	1. Decedent's Name (First	t, Middle,Last)			2. Date of Death	V	3. Time of Death
Medical Examiner	Kenneth	Harlan	Snoots		June 1, 2012	y Year	1959 hrs
	4a. Facility Name (if not in	stitution, give stre	et and number)	4b. City, Town, or Location of	of Death	4c. County of Death	n
				1		D . III	

eilleur rianan		1- For State Certifi	icate of		nemai riyg	Reg.	201	2 1//1
Physici Medical Exami	an/	1. Decedent's Name (First, Middle,Last) Kenneth Harlan Snoots				Date of Death Month D	Day Year	3. Time of Death 1959 hrs
nedical Exami	liéi	4a. Facility Name (if not institution, give street and number) 3922 Vero Road	4	4b. City, Town, or Loca Halethorpe		June 1, 2012	4c. County of Death Baltimore Cou	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last b	birthday) Yrs.	Months Days I	Under 24Hrs. Hours Min.	8. Date of Birth(March 1	MM/DD/YYYY) 9. Bir 1957 Foreig	
d 10w any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town MD Howard Mt.	wn or Locati Airy	on				10d. Inside City Limits 1 Yes 2 X No
death with the Maryland or items 23a or 28a-f show must be notified at once,	Director	10e. Street and Number 17820 Old Frederick Road		10f. Zip Code 21771		10g.	Citizen of What Cou	ntry?
H - 1	by Funeral	11. Marital Status 1 Never Married 2 Married 12 Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes 2 No If Yes 2 No If Yes (Rev Year or Dates:	If Yo	s Decedent of Hispani es, specify Cuban, Me Yes 2 X No sp	exican, Puerto Ri	can, etc.)	White, etc. Specify: wh	can Indian, Black, ite
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	17. Father's Name (First, Middle, Last) Harlan Andrew Snoots	48 M T			izabeth	Robertson	7.0.1
MD 2 nd 2 should alth and M em 27 is m	٩	Mrs. Debbie Snoots (spouse)	17820	Address (Street and Old Frede: ition (Name of cemeter	rick Rd	., Mt. A		1771
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ळ 됨음류道 Physician	VI V	23a. Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line.	P.0	0. Box 195	Sykesv	ille, MI	D 21784	Approximate Interval Between Onset and
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To the Hospita within 24 hours To the Funeral completely fille		4 Homicide determined (Specify) Office 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or			ınd place, and du	ie to the cause(s		
To t with To tl	Medical	and manner stated. 29b. Signature and title of certifier		29c. License nu			29d. Date signed (Mo	
		Theodor U. Thing Thym	co).	O.C.M.E	OCME	,	June 2, 2012	
10		30. Name and address of person who completed cause of death (Item 23a	-	900 W Baltimore	Street Ral	timore MD 1	21223	

State 31. Date filed (Month, Day, Year) istrar JUN 0 5 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. 20 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician/ 5.55 PM SOTHORON DOLORES JUNE 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MOSPITAI BAUTIMORE MARBOR If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 216-28-7909 Director 1 □ M 2 🗶 F 80 Maryland 02/15/1932 Usual Residence of Deceden 28a-f shov 10c. City, Town or Location 10d. Inside City Limits aţ 10a. State Director Examiner must be notified 1 Yes 2 X No Maryland Anne Arundel Linthicum 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 0 21090 23a 203 Mountain Road United States items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: nan "natural", Specify: White 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry Je filed wto... ral Hygiene. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Coast Guard Exchange the Cashier should be filed with h and Mental Hygien 7 is marked other th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျ Unknown Raivel Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once, 608 Saks Street, Smyrna, Delaware 19977 Ralph Sothoron/ Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 06/07/2012 Crownsville, Maryland 4 Denation 5 Other (Specify) Crownsville MD Vets 21. Signatu a of Fune al Serv 22. Name and Address of Facility Kirkley-Ruddick Funeral Home Licens 421 Crain Highway SE, Glen Burnie, MD 21061 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition MEDMONIA Medical resulting in death) Due to (or as a consequence of) Examiner FXA SFRBATIO COPD Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No been signed by the atter Day Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown HEART FAILURE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an FAILURE RENAC Director: After this certificate has performed 26. Place of Death (Check only one) 25 Was case referred to medical filled in by the funeral director, Be Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 24 hours after death. 5 Pending work? 1 ☐ Yes 2 ☐ No 1 Natural 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Hosp within 24 hou To the Funer completely fi 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3mmfales RES 001 JUNE, 03, 2012 O HIREN PATEL, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) m BACTIMORE, MARYLAND SOUTH HANOVER STREET, 21225 31. Date filed (Month, Day, Year) 32. Registrar's Signature State park JUN 0 5 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 📗 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 31^{Day} Physician/ Month MAY 2012 8:45 A M FRANCES STARK Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** BALTIMORE NORTH OAKS HEALTH CENTER BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🗶 F Months Days Hours Min 04/19/1918 94 Director 043-16-2671 Usual Residence of Decedent or 28a-f show 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 Yes 2 X No BALTIMORE BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 725 MT. WILSON LANE, #224 21208 USA death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 XNo Specify. Specify: and Mental Hygiene. is marked other than "natural", 3 😾 Widowed 4 🗌 Divorced Completed WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) JOHNS HOPKINS UNIVERSITY College (1-4 or 5+) Elementary/Seconday (0-12) **EDITOR** 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be: Department of Health and Menta Important. If item 27 is marked any injury or other traumatic ewonce. 2 SKOLNICK ASTRACHAN MAE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JONATHAN STARK/SON 6830 K HAYLEY RIDGE WAY, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State OHEB SHALOM MEM. PK. 06/04/2012 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furn ral Service Lice 3 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ Nou disease or condition -ecurrent Medical resulting in death) Examiner Sequentially list conditions, il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 or Attending Physician: The law requires that the death certificate attending ph F FEMALE: nse. 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death signed by the a 1 ☐ Yes ∠ Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has death? certificate 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🗌 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of nours after death.

neral Director: After the filled in by the funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completed filled i Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 037573 30. Name and address of person who npleted cause of death (Item 23a) (Type, Print) 2835 ZIRell MA 31. Date filed (Month, Day, Year State JUN 0 5 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $\operatorname{Jum}^{\scriptscriptstyle{\mathsf{Month}}}$ 2012 4:00 Рм **Ma**rgaret Jane Swain Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Parkville Oak Crest If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Maryland 1 □ M 2 🛚 F Months Days Hours Oct. 5ay, ⁴924 Director <u>218-12-7226</u> Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City. Town or Location Director 1 Tyes 2 No MD Baltimore Ruxton 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 7620 L'Hirondelle Club Road 21204 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. is should be filed within tz mour-alth and Mental Hygiene. n 27 is marked other than "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12College (1-4 or 5+) Executive Secretary Health Insurance permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary M. Doonan John S. Teipe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7620 L'Hirondelle Club Road; Ruxton, MD 21204 Margaret S. Ricely / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Mt. Maria Cemetery 6/6/2012 Towson, MD 4 Donation Other (Specify) 1050 York Road 22. Name and Address of Facility 21. Signature of Towson, MD 21204 Ruck Towson Funeral Home, Inc. ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. 23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one can Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and I for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause give in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by (coronary entery Disagse 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy within 24 hours after death.

To the Funeral Director; After this certificate To Be 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) examiner? Hospital: 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 4/29//2 Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred found laying on floor in her 1 Natural 2 Accident 5 Pending 1614 Investigation 6 Could not be 28e. Flace 1 Injury - At home, farm, street, factory, office building, etc. (Specify) (ALF Apt) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Sity or Town, State) ō Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Datersigned (Month, Day, Year) npleted cause of death (Item 23a) (Type, Print) Parkville, MD 21234 8500 Walther

State Registrar

Margaret

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First Middle, Last) 2 Date of Death 3. Time of Death Physician/ Medical (if not institution, give street and number) 4a, Facility Nam 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min 170-82-3322 Director 1 □ M 2X F 33 03/26/1979 Poland items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Examiner must be notified at Director PA 1 Yes 2 X No Lancaster Lancaster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 447 Lupine Circle 17602 Poland Poland 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc þ ō 1 Never Married 2 K Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: White "natural", 3 - Widowed 4 - Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Sales Associate 12 Retail Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Mujedin Kurshumliu Lilianna W. Denisowska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lilianna W. Kurshumliu - Mother 310 Oak Thorne Lane, Lancaster, PA 17602 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mellinger Mennonite 4 ☐ Donation 5 ☐ Other (Specify) 6-2-2012 Lancaster, PA 11824 Reisterstown Rd. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility non Eline Funeral Home Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phy ician disease or condition MARIE Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate outco. E. Tol Olambia Gause (Disease or injury Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed physician and sthe burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performe 1 🗌 Yes 2 🗌 No Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 1 🗌 Yes 2 No 1 Plnpatient 2 ER/Outpatient 3 DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at ë 28d. Describe how injury occurred 24 hours after death. Funeral Director: After injury Natural 5 Pending Certificat 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29c. License number

State Registrar 31. Date filed (Month,

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nd address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 30 Medical Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City Levindale Hospital 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. Social Security Number 212-40-0793 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🖾 M 2 🗆 F 11770371942 Director 69 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Funeral Director Owings Mills Baltimore 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21117 4 Liberty Ridge Ct. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Completed by 1 Never Married 2 XMarried Yes 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sanitation Owner 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Doris Virginia Walsh Norbert Joeseph Spindler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4 Liberty Ridge Ct., Owings Mills, MD 21117 19a. Informant's Name/Relationship (Type, Print) Charlene Spindler/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or oth 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 6/01/2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home 21. Signature of Furneral Service Licensee 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph, i ian/ disease or condition resulting in death) Medical (or as a consequence of) Examine Sequentially list conditions, Examine Due to for as a conse it any leading to immedicause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of). resulting in death) Last s been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 2 🗌 No Yes 25. Was case referred to make a examiner? 26. Place of Death (Check only one) Be ပ 1 Tes ER/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No death. 2 Accident
3 Suicide Investigation filled by the 24 hours a er dee e Funeral Director 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the Signature a signed (Month, Day, Year) Baltimon 21215

Registrar
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Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Under 1 Year If Under 24Hr	s. 8. Date of Birth(M		rthplace (State or
Director		214-23-7113 1 M 2 F 28 Yrs. N	Months Days Hours Mir	06 02	83 Forei	gn puntry) MD
/ any		10a. State 10b. County 10c. City, Town or Location	-			10d. Inside City Limits
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Mary r 28a ed at	Jec		f. Zip Code	10g. (Citizen of What Cou	intry?
pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygier than "natural", or items 23a or 28a-f sho Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		5726 Fenwick Ave	21239	taccify Voc or No		rican Indian, Black,
ath wi	Funeral Director	1 v Never Married 2 Married Armed Forces? If Yes, s	specify Cuban, Mexican, Puerto		White, etc.	rican Indian, black,
tter de		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes	s 2 X No specify:		Specify: B	lack
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withir jene. ner th Medi	E C	12th grade 4yrs Contrac	t Administra	e (First, Middle, Maid		t of Defe
al Hyg	Be	Benjamin L. Turner		ie Wilso		
Menta Menta mark c even	To B	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Add	dress (Street and Number or	Rural Route Number,	City or Town, State	e, Zip Code)
2 sho th and 27 is umati		Benjamin L. Turner-Father 3522 W	ild Cherry			
Healt fitem		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State crematory or other p		Date 20	c. Location - City or	r Town, State
Pages sent of		4 Donation 5 Other Specify: King Memor	ial Park 6/	4/2012 W	oodlawn	, Md
epartn aports jury o		21. Signature of Funeral Service Licensee 22. Name	and Address of Facility			
-	10 .0	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the m) Wabash Ave	, Baltim	ore Md	21215 Approximate Interval
ysician Veolical		failure. List only one cause on each line.	lode of dying, such as cardiac	or respiratory arrest, s	shock, of fleat	Between Onset and Death
aminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):				- Bouil
		Sequentially list conditions, b				
	ner	if any, leading to immediate cause. Enter Underlying Cause				
	cam	(Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			7-	-
eath certificate be executed attending physician and or use as the burial - transit	cal Examiner	d				
be exe ician a ırial -		UNPENDED AMENDED				
phys the bu	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal d	eath 3 Ectopic pregn		23d. Date of deliver Month	y Day Year
ending use as	ciar	past 12 months?	eath 3Ectopic pregn (Specify)	laricy	WOTH	Day real
e death the att ed for	hysi	1 Yes 2 No 9 Unknown 9 Unknown		1		
w requires that the as been signed by t should be detache	by P	Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.			the cause of death? bably 4 Unknown
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as bee	Completed			autopsy performed	prior to	completion of cause of
certificate has bector, page 2 sh	ĕ			1 ✓ Yes 2		es 2 No
ysician: his certifi director,	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Qutnatient 3	26. Place of Death (Check		م القاميد	. 0
rhyst er this ral dir	입	1 Yes 2 No Prospital 1 Inpatient 2 ER/Outpatient 3 27. Manner of Death 28a. Date of Injury 28b. Time of Injury		ng Home 5 Res		ir: Scene
offending Fridge of the control of the funeral of t	ation	1 Natural 5 Pending FOWND: 1720 hrs Investigation May 27, 2012 1720 hrs	lf	I Data Nation City		
the Hospital or Attending Physician: The law requires that the death certificate be thin 24 hours after death. The Tay hours after death. The Function: After this certificate has been signed by the attending physicinpletely filled in by the funeral director, page 2 should be detached for use as the burn.	Certification:	3 Suicide 4 Homicide 6 Could not be determined (Specify) Single Family Home	ctory, office building, etc.	or Town, State 5726 Fenwick Ave		ural Route Number, City
To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated.	in my opinion, death occurred	at the time, date and	place, and due to th	ne cause(s)
ł	Ž	29b. Signature and title of certifier	29c. License number		d. Date signed (Mo	onth, Day, Year)
Bir		tate by - Holler -	O.C.M.E.	M	ay 28, 2012 ————	
9		Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 900	W Baltimore Street	Baltimore MD 2	1223	
		Patricia Aronica-Pollak MD. Assistant Medical Examiner 900	vv. Daililliole Stieet, I	Daiminole, IVID 2	1223	

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 11:08 AM Oliver Ameal Talieferro 05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Baltmor VA Medical Cente If Under 1 Year | If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days (Month, Day, Year) 216-44-2548 **Director** 1 ₹ M 2 □ F 1948 Jan 22, Usual Residence of Decedent <u>Maryland</u> show 10d. Inside City Limits 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at Director 1X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 by Funeral 513 Allendale Street iral", or items ? Examiner mus permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) carpenter factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Elaine Hughes Oliver Paul Talieferro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4231 Mary Ridge Drive Randallstown, MD 21133 Jacqueline Laprade/cousin 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in state ton de Pade, Director . Sign 28 tate Addato Myllib Board 655 W. Baltimore Street 21201 611 Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, repeat failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) and the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE asn yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No eral Director: After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural injury work? 5 Pending Investigation Accident Suicide 6 Could not be 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Eurhour MD P2727 5122/12

Registrar

DHMH 17 Rev 06-2011

State

Greene Street Baltmore MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10

32. Registrar's Sigrature

Einhor

JUN 0 5 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 June 8:00 A M Tozoni 01**e**g Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Rockville Hebrew Home of Greater Washington 9. Birthplace (State or Foreign Country)
Russia Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Age (In yrs. last birthday) **Funeral** Days 1 🛛 M 2 🗆 F Months Hours September 30, 1927 Director 84 180-70-1226 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10a, State Director 1 X Yes 2 No Rockville Montgomery Maryland 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 20852 261 Congressional Lane #519 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) University Professor of Physics Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ည Catherine Tsiolkovsky Valentin Tozoni 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12219 Greenleaf Avenue, Potomac, Maryland 20854 Ihor Murashchyk/Son-in-Law 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) June 3,2012 Rockville, Maryland Parklawn Memorial Park 21. Signature of Funeral Service Licensee Robert Adres Pullipliney Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final -Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Dementia Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed plnous peen (24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed?
1 Yes 2 No 1 Yes 2 No certificate 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) ျှ this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) tarli minn D00648 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville, MD Rd montrose Fazli MD 6121 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 3, 2012 Nancy Lee Thompson 9:16 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Lutherville 10937 Mays Chapel Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours **Director** 214-24-5603 1 M 2 X F 10/12/1926 Mary land 85 Usual Residence of Dec permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importantt If item 27 is marked other than "natural", or items 23a or 28a-f show amportantt If item 27 is marked other than "natural", or items 23a or 28a-f show ampirity or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Lutherville Mary land 1 🗆 Yes 2 🖹 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10937 Mays Chapel Road 21093 U.S.A. y Thompson D00 6/3/2012 T00 9:16am Baltimore, Maryland 21215-0036 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 K No Specify If Yes, Give Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank G. Schenuit Hilda Koester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Clements / Daughter 535 Piccadilly Road Towson, Maryland 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other (Specify Entombrent Dulaney Valley Mem. 6/7/2012 Timonium, Maryland Signature of Funeral Service I 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Dementia Alzheimer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter onderwing Cause (Disease or injury Due to (or as a consequence of) use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Year Day Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy performed? Yes 2 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifical completely filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗹 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 -27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of o 29d. Date signed (Month, Day, Year) unin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PU Box Chen 19099 Towson lexander 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Montl Physician/ 21:35 Barbara Elizabeth Tolker 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPITAL BALTIMOR N/A Social Security Number 7. Age (In yrs, last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. (Month, Day, Year) 213-20-9162 **Director** 1 □ M 2**X** F 85 July 7, 1926 Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location must be notified at Director 1 Yes 2 No Catonsville Baltimore Maryland 10f. Zip Code 10e Street and Number ò 10g, Citizen of What Country? 23a Funeral 21228 4 Rumford Drive Unit 101 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married o þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) 12 College (1-4 or 5+) the Home Maker Own Home and Mental Hygier is marked other t event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John Ford Grace Long other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Stone Manor Court Towson, Maryland 21204 Pamela Bowman, Daughter Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1
Burial 2
Cremation 3
Removal from State 05/30/12 4 Donation 5 Other (Specify) Metro Crematory Inc. Baltimore, Maryland Signature of Funeral Service Lioensee Thomas Gregor Remarkant Address of Facility Cremation Society Of Maryland, 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ DAYS disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner cause. Enter Underlying igned by the attending physician and be detached for use as the burial-transit Cause (Disease or injury that initiated events DIABETER resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ FIBRILATION 1 Tyes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No CANCER 24a. Was an has within 24 hours after death.

To the Funeral Director; After this certificate Yes 2 V N filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗷 No 0 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Medical Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined or Hospital 29a. Certifier Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only on 29b. Signature and fittle of certifie 29c. License number 29d. Date signed (Month, Day, Year) 05 291 mpleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who o

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State

Registrar

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AVENUE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** June 2, 2012 Mark William Utter 9:30a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Harford Havre de Grace Harford Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Months Days Hours Director 091-46-7835 58 11/27/1953 New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Wayes 2 □ No Harford Havre de Grace Direct Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21078 205 Seagull Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\overline{\Overl Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: þ Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance 12 Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be VanGorden Doris ဥ William Utter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 Seagull Dr., Havre de Grace, MD 21078 Karen K. Utter (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If it
any Injury or o 1 ☐ Burial ②CCremation 3 ☐ Removal from State R.A.Ferris & Company 6/4/2012 West Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001 21. Signature of Funeral Service Licensee ustensine 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** wag concer /Medical Due to (or as a sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit Due to (or as a consequence of): Box 68760 the Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No signed by the O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 DINO 1 ☐ Yes 2 ☐ No 1 □ Yes **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 □Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🛮 🚾 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6/2/2012 D0064015 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arenne Hurre de Grace MO 21078 501 Divilson Union EVENNE 31. Date filed (Month, Day, Year) _ _ - - . State Registrar

W DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 1:25 P M Edwin Oliver Vandeven June Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Frederick 1003 Eastbourne Terrace Frederick Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Months Davs Min 487-28-3991 **Director** 1 🕱 M 2 🗆 F Vrs 1920 Dec 16, Missouri Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 X Yes 2 No Frederick Frederick MD 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? "natural", or items 23a or idical Examiner must be r Funeral United States 21702 1003 Eastbourne Terrace within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: 3 X Widowed 4 Divorced Completed Year or Dates Caucasian the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) filed within 72 al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Electrical Engineer Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental 27 is marked of traumatic ever ၉ Monica Shanks John H. Vandeven permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia L. Stevens / Daughter 1003 Eastbourne Terrace Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2X Cremation 3 ☐ Removal from State Final Journey Crematory 6/7/2012 Woodbine, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter medisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death
Weeks Immediate Cause (Final Physician/ Failure Congestive Heart Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) death certificate be executed burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Pregnant at time of death 5 Other (specify) the 9 Unknown Hospital or Attending Physician; The law requires that the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 Yes 2 X No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform Yes 2 No 1 ☐ Yes 2 ☐ No certificate director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 🔀 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) filled in by the funeral Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury Investigation Accident 24 hours after deatlerners Funeral Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I only one) 29b. Signature and ttle of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 4, 2012 D54616 By 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shawn Buki 310 West 9th Street Frederick, MD 21701

Registrar

31. Date filed (Month, Day, Year)

JUN 0 5 2012

32. Registrar's Signature

WILLOUGHBY HERBERT Baltimore, Maryland 21215-0036 atient known Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Houghb Month ee 01:15 AM June 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore NI 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) Director 1 M 2 🗆 F 67 26,194 MD 28a-f show 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director notified Kanda H more 1 Ves 2 No 10e. Street and Number Apt 2 10g. Citizen of What Country? must be 23a Completed by Funeral 124 iral", or items 2 Examiner mus 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married If Yes, Give Year or Dates. AIT Force 1 Yes 2 No Specify. Black "natural", 3 Widowed 4 Divorced Specify: ed other than "nature event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working DO NOT use retire Elementary/Secondary (0-12) College (1-4 or 5+) id Mental Hygiene. marked other tha Floor WBAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Houghbu Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 👌 🔢 ᢃ Schnaper 3801 Apt 124; Willoughb Kandallstaux, Mi 20a. Method of Disposition cemetery, crematory or other place) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State altimore. 4 Donation 5 Other (Specify) Signatur uneral Service Li uneral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line erval Between Immediate Cause (Final Onset and Death Physician/ Acute myocardial disease or condition resulting in death) day Medical Due to (or as a consequence of) **Examiner** day Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury Due to (or as a sonsequence of): burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) signed by the atter in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Day 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown bleed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 2 No ☐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work?
1 Yes 28d. Describe how injury occurred injury ☑ Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 2 No within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kaur, MBBS poseet RES-000 June 4,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nai Hospital of Baltimore. State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 07:06 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and numbe **Examiner** mont 9 akoma ank /Ashinigton 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** (Month, Day, Country) 1 M 2 D F D.C 577-96-259 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 les 2 No LINST 10g. Citizen of What Country? 10f. Zip **6**0de 10e. Street and Number by Funeral FARAgut 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired)

UN-Employed (Specify only highest grade completed) College (1-4 or 5+) Flementary/Seconday (0-12) 2 Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last, ည dith BNXANE W1951 19b. Mailing Address Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) VART enki 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 M Cremation 3 Removal from State Riverdele Park Md. 06-01-12 Rivadule PARK 4 ☐ Qonation 5 ☐ Other (Specify) 22. Name and Address of Facility
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\$14 UPShun ST. New re of Funeral Service Licenses , MO 1182 Signatu washigton D.C. Louil 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EPS IS Phylician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner STAGE GV-RENAL DIJEAS Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown VASCULAR DISEASE PERIPHERAL 24b. Were autopsy findings available prior to completion of cause of death? FIBRILLATION autopsy performed? Yes 2 2 🗆 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 2 4 No 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Investigation Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 22 Orach D68005 2912 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 LARROLL AVENUE, TAKOMA PARK JENNIFER OBIADIL MP 31. Date filed (Month, Day, Year) State JUN 0 5 201 Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8.12.15&16a&b Per ANA BD G929 7/24/2012 JH State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Gertie M. Wilson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Western Maryland Health System Cumberland **Allegany** Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Days Min. **Director** 500-05-3856 1 M 2X F 1920 92 Feb Missouri Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD **Allegany** Cumberland 1 Yes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 512 Winifred Road 21502 USA 11 Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 X Yes 2 X No If Yes/ Give 1943-46 Year or Dates. "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white Specify: 3 X Widowed 4 Divorced injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) life nurses raide healthcare telephone operator communications is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Maximilian Ferdinand Pachi Etta Marget Muse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health an Important: If item 27 is any injury or other trau Mary Wilson/daughter 609 Henderson Avenue Cumberland, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☑ Donation 5 ☐ Other (Specify) Signature of Bareral Service Ronald State Anatomy Board 655 W. Baltimore Street Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. 23a. Part 1 shock Approximate Immediate Gause (Final disease or condition resulting in death) Unset and Death S Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine physician and the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) for in the past 12 months?

1 Yes 2 No Day Month Year 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The law performed 2 No 1 🗆 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \(\text{Yes} 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural Pending 1 Yes 2 Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatui and title of certifier nd address of person who completed cause of death (Item 23a) (Type, Print) James M. Raver Western MD Medical Center Cumberland, MD 21502 31. Date filed (Month, Day, Year) 32 Registrar's Signatur State JUN 0 5 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 40 PM 2. Date of Death Physician/ ZB 2/01/2 Medical (if not institution, give street and number) yn, or Location of Death **Examiner** 4c. County of Death 15 ACTIMOR 5 9. Birthplace (State or Foreign 6. Sex Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Hours 217-38-9662 1 🗆 M 2 🔀 F Director 70 Sept 16, show 10c. City, Town or Location 10d. Inside City Limits at Director must be notified 28a-f 1X☐ Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 6 10g. Citizen of What Country? 23a Completed by Funeral 600 Light Street #801 21230 USA ural", or items ? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces?
1 Yes 2 No permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: white 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk un 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unk unk Be unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301~St.~Paul~Place~Baltimore, MD~21202Mercy Hospital 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 📉 Other (Specify) Signature of Funeral Service Licen 22. Name and Address of Facility Burald S Anatomy Board 655 W. Baltimore Street Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part Approximate Interval Between set and Reath shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) VODENA Physician/ EEDING Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) physician and is the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be. 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 use as 1 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Year Pregnant at time of death 9 Unknown g Unknown is certificate has been signed by director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 🗌 Yes Inpatient 2 - ER/Outpatient 3 - DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature

State Registrar 30. Name and address of be

31. Date filed (Month, Day, Year)
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death (Item 23a) (Type, Print)

32. Registrat's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last, 2. Date of Death Day 2012 Year 19 Physician/ MAN 3:30 A M Mams Jane Medical Facility Name (if not institution, give street and number)

lashington Adventist Hospital 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Park Montgomer Takoma 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9 Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Hours 62 1 M 2 X F Director ams 23a or 28a-f show r must be notified at 28a-f show 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 20747 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: "natural" 3 Widowed 4 Divorced t of Health and Mental Hygiene. If item 27 is marked other than "natur or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Government lasters Be ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St. Michaels abbagostalk 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) ō Department of Important: If any injury or once. Name and Address of Facility 4594 Beech Ro Freeman Funeral Services 21. Signature of Funeral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Shock Examiner Se Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 signed by the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
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Unknown 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed' 1 Yes 2 No Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending s after death. 1 🗌 Yes 2 🗆 No filled in by the 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a

To the Funeral D

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00060100 MD 5 Almina Silver Jag 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16 ATOMED

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Division of To the Hospital or Attending Phe within 24 hours after death. To the Fineral Director: After to completely filled in by the funeral	Medica	one) 2 Medical Exa	aminer: On the b and man	asis of exam mer stated.	nination a	and/or investiga	ition, in m	opinion,	death occ	urred at	the time, date	and p	olace, and d	ue to the	e cause(s)	
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		30. Name and address of person Pamela E. Southall, M		cause of de ant Medie			0 W. Ba	ltimore	Street,	Baltin	nore, MD 2	21223	3			
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State of Maryland / Department of Health and Mental Hygiene Michelle Denise Webb 2012 17735 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day May 26, 2012 0550 hrs **Medical Examiner** Michelle Denise Webb 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1522 Hazel Street Apt. 1 **Baltimore** 9. Birthplace (State or 5, Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) **Funeral** Months Days Hours Director 08/17/1961 Country) Maryland 215-84-9544 1 M 2 XF 50 Yrs Usual Residence of Deceden 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 X Yes 2 No Curtis Bay N/AMaryland hours after death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21226 1522 Hazel Street, Apt. Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Yes 2 X No 4 Divorced If Yes, Giva Year White 1 Yes 2X No specify: 3 Y Widowed Specify: ò 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 McDonalds Cook 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leona Apple Be Donald T. Palen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1522 Hazel Street, Apt. 1, Curtis Bay, MD 21226 Ricky Oxendine 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 06/01/2012 Baltimore, Maryland Metro Crematory Inc. Donation 5 Other Specify: 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Road, Baltimore, Maryland 21228 Part lenter the disease, or compilations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Mixed drug (methadone, nordiazepam and **Physician** Between Onset and /Medical Death a Chlordiazepoxide) Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical AMENDED 23a, 27, 28a-f, per me, g928 6-8-12 sm sician a X UNPENDED Division of Vital Records, P.O. Box 68760, attending physi for use as the bu 23d. Date of delivery IF FEMALE 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the Fetal death Live birth 3 Ectopic pregnancy Month Dav Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. á 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? ✓ Yes 2 No After this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) æ Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗹 Other Scene ER/Outpatient 3 DOA 1 Yes No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural unknown 1 Yes 2 X No 5 | Pending · death. fd 5-26-12 fd 5:20 am Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1522 Hazel St. Apt 1 3 Suicide 6 X Could not be determined found at home (Specify) Baltimore, MD. To the Funeral 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E May 26, 2012 30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) istrar JUN 0 5 2012 2. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

n Suk Yoo		- For State Registrar	Certificate o		Re	eg. No. 2012	2 1773
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last)	You		2. Date of Deat Month June 3, 20	Day Year	3. Time of Death 0440 hrs
		4a. Facility Name (if not institution, give street an Route 97 north of county line	d number)	4b. City, Town, or Location of De Woodbine	ath	4c. County of Death Carroll	
Funeral Director		5. Social Security Number 6. Sex 1 6. Sex	7. Age (In yrs. last birthday)		Hrs. 8. Date of Bird April	th (M4DD196) 9. Birth Foreign	nplace (State or intry) Kurea
Maryland 28a-f show any 1 at once.	tor	Usual Residence of Decedent 10a. State 10b. County Carroll 10e. Street and Number	10c. City, Town or Loca	1.1	140	Dg. Citizen of What Coun	10d. Inside City Limits 1 Yes 2 No
ith the Mar 23a or 28s	Funeral Director	603 Corsair	Decedent Ever in U.S. 13. W	21784 as Decedent of Hispanic Origin?		USA	
s after death w ral", or items	by Funer	1 Never Married 2 Married 1 1 Never Married 2 Married 1 1 Never Married 2 Never Married 1 Never Married 2 Never Married 3 Never Married 2 Never Married 2 Never Married 3 Never Married 2 Never Married 3 Never Married 2 Never Married 3 Never Married 2 Never Married 3 Neve	ed Forces? If Yes 2 No 1	Yes 2 No specify:	erto Rican, etc.)	White, etc.	sian
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygene. ant: If item 27 is marked other than "natural", or items 23a or 28s-f sho or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Education (Specify only highes Elementary/Secondary (0-12) Colle 1.2	ge (1-4 or 5+) during m	nt's Usual Occupation (Give kind nost of working life. DO NOT use	retired)	16b, Kind of Business/Ir	idustry
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	To Be Co	17. Father's Name (First, Middle, Last) Vun 1-a 19a. Informant's Name/Relationship (Type, Print	19b. Mailin	g Address (Street and Number	or Rural Route Num	19 DK	Zip Code)
nore, MD 2 ages 1 and 2 shou at of Health and Int t: If item 27 is no other traumatic	-	Hae Moo Voo	20b. Place of Dispos	corsor C	H, Syk	esvile, M 20c. Location - City or 1	D 21784
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27		1 Burial 2 Cremation 3 Remo 4 Donation 5 Other Specify: 21. Signature of Funcial Senice Licensee	Hrden	Name and Address of Facility	5/2012	Hanover	, MD
Physician	2	23a. Part I. Enter the disease, or complications to	seel Il. 10	220 Guilfor	d RCl c or respiratory arre	Jessup est, shock, or heart	Approximate Interval
Examiner	1	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or	Injuries as a consequence of):				Between Onset and Death
- 193	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	as a consequence of):				
cuted nd transit	I Examiner	(Diagona un injury that initialed C.	as a consequence of):				
50, te be executed ysician and burial - transit	ledical	UNPENDED AMEND				22d Pate of delivery	
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and appliedly filled in by the funeral director, page 2 should be detached for use as the burial - transi	21	3b. Was decedent pregnant in the past 12 months?		etal death 3 Ectopic pretther (Specify)	gnancy	23d. Date of delivery Month Da	ay Year
P.O. E	<u>a</u>	Part II. Other significant conditions contribut	ng to death but not resulting in the	underlying cause given in Part I.		bacco use contribute to the	
Division of Vital Records, rai or Attending Physician: The law requir rs after death. **I Director** After this certificate has been sited in by the funeral director, page 2 should be a bar of the funeral director, page 2 should be a second to the funeral director.	Completed				24a. Was a autops perform	sy prior to co m <u>ed</u> ? death?	opsy findings available ompletion of cause of
ital rician:	器	25. Was case referred to medical examiner?	Inpatient 2 ER/Outpatient	26.Place of Death (Che		Residence 6 🗸 Other:	Scono
n of Viding Phys	의: 10	1 Yes 2 No	Date of Injury 28b. Time of ND:			low injury occurred	CONTRACTOR
Divisior ospital or Attend hours after death uneral Director: ly filled in by the	Certification:	2 Accident Investigation Jun 3 Suicide 6 Could not be	3, 2012 0417 hrs Place of Injury - At home, farm, stre cify) Major Road / Highway	et, factory, office building, etc.	or Town, St	treet and Number or Rura tate) n of county line, Wood	
To the Hosp within 24 ho To the Func completely f	Medical C	one) 2 Medical Examiner: On the ba	best of my knowledge, death occu asis of examination and/or investiga her stated.				
H 3 H 8	¥.	29b. Signature and title of certifier		29c. License number O.C.M.E.		June 3, 2012	th, Day, Year)
	t	80. Name and address of person who completed Zabiullah Ali, M.D. Assistant Me	cause of death (Item 23a)	Baltimore Street, Baltimor	re, MD 21223		
Sta Regist		31. Date filed (Month, 2012ar) Leverin	2. Register's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 5 Physician/ 03:47AM YEATMAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore VA medical center Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Hours Director 217-54-5502 1 X M 2 🗆 F Sept 18, 1950 Maryland 61 ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Talbot Easton MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21601 9 S. Park Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 Yes 2 1 Never Married 2 Married þ Maryland 21215-0036 1 Tes 2 No Specify: If Yes, Give **'**67-69 Specify: white 3 Widowed 4 X Divorced Completed Year or Dates. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk unk 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental I 2 Arthur Yeatman Janet Taylor other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st.
Department of Health ar
Important: If item 27 is 10 N. Greene Street Baltimore, MD Baltimore VA Medical Center Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🕅 Other (Specify) in state 22 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street LFune I Se Ronal I 21201 Baltimore, MD inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 Approximate shock, o heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Procuversulting in death) Interval Between Onset and Death Physician/ Pneumonia Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exam attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical requires that the death certificate be Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Other (specify) Pregnant at time of death been signed by the should be detached 1 L Yes 2 L 9 L Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending injury 2 No Investigation filled in by the 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical

• Hospital or Attending Physician: The 24 hours after death.
• Funeral Director: After this certificate within 2 To the F

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Baltimore MD ZIZOI

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. Greene St Amelia Fiastro

JUN 0 5 2012

32. Registrar's Signature

State Registrar 29a. Certifier

(Check

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2Bay 10:05 AM 2012 Abdu Rashid Yahya /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Yea May 15, 1 **Funeral** Days Hours Months X□ M 2□ F 81 DE 222-16-2727 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1

Yes 2□No Director MD Baltimore City Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1650 Woodbourne Avenue Apt. 103 21239 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 🚺 If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 **X** No 1 □ Yes 🍒 □ No Black Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Music 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Johnson Unknown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Maryam J. Yahya (Wife) 1650 Woodbourne Ave., Apt. 103 Baltimore, MD 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) 5/31/2012 Lake View Mem. Park Sykesville, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licensee M00764 PO Box 195 Sykesville, MD 21784 HZEL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CVA **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Division or Vital Records, P.O. Box 68760burial-trar The law requires that the death certificate be execu Due to (or as a consequence of) physician Physician/Medical the attending p for use as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1∏ Yes Hospital or Attending Physician; funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

JUN 0

29c. License number 00069314 29d. Date signed (Month, Day, Year)

Partille MD 21234

30. Name and address of person who co npleted cause of death (Item 23a) (Type, Print) rade

State Registrar

Medical

(Month, Day, Year) 5 2012

and manner stated.

24 hours a

2

completely within 2.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5 2012 Year Naser Alimohammadi Physician/ 10:15a4 17 Medical 4a. Facility Name (if not institution, give street and number)
Gilchrist Center 4b. City, Town, or Location of Death 4c. County of Death Howard **Examiner** 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number 214-75-6942 Funeral Country) Iran 63 Months Days Hours Min. 2/6/1949 1 ¥M 2 □ F **Director** 28a-f show 10d. Inside City Limits Count 10c. City Town or Location Ellicott City **Funeral Director** Howard notified 1 Yes 2 No 10f. Zip Code 21 0 4 4 10g. Citizen of What Country? ō ms 23a or must be n 5505 Waterloo Rd. Apt#404 Iran items 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian. Examiner Armed Forces? Black, White, etc ò by 1 Never Married 2 X Married Specify: Persian permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates "natural", Completed 3 Divorced 4 Divorced Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. life. DO NOT use retired) unknown Elementary/Secondary (0-12) College (1-4 or 5+) Teacher School the of Health and Mental Hyg item 27 is marked othe other traumatic event, Be 7. Father's Name *(First, Middle, Last)* Abbas Alimohammadi 18. Mother's Name (First, Middle, Maiden Surname) ္ပ Zinat 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code 5505 Waterloo Rd. Apt#404 Ellicott City MD 9a. Informant's Name/Belationship (Type, Print)
Mahbod Alimohammadi/son Department of Health ar Important: If item 27 is any injury or other trau 20c. Location - City or Town, State Frederick, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of 5/17/12 1 XBurial 2 Cremation 3 Removal from State Alfirdaus Cemetery

Alfirdaus Cemetery 4 Donation 5 Other (Specify) 150 Rd. Lanham Severn Lanham, MD. 20706 21. Signature of Funeral Service Licenses 22. Name and Address Hussains Name and Address of Facility MO Islamic F.S 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ stanoen conc disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or Injury that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Fctopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death ☐ Pregnant ☐ Unknown been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 Yes 2 No 1 Yes 2 No After this certificate **Division of Vital** funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 X No 9 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) HOTOLO 28a. Date of injury (Month, Day, Year) Medical Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation within 24 hours after death To the Funeral Director; 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one 29b. Signatur and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30/Name and address of person who completed cause of death (Item 23a) (Type, Print) enelane

DHMH 17 Rev 06-2011

Registrar

Date filed (Month, Day, Year)
NAY 2 2 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>012</u> Physician/ Month Sylvia J. May Adams 2:02A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Saint Thomas More Nursing Rehab Center <u>Hvattsvi</u> Prince Georges Social Security Number If Under 1 Year 8. Date of Birth
(Month, Day, Year)
Dec. 16.1 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral If Under 24 Hrs Hours Min 1 M 2 X F Days 443-38-7795 Yrs Director 76 1935 Ohio Usual Residence of Decedent 23a or 28a-f show ast be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director MD 1 Yes 2 No PG Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4922 LaSalle Road 20782 United States "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. , or 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: Completed 3 XWidowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working r than " t the M life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N 4 Manager Kmart Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Samuel Wallace Edna Grav 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6831 8th St. DC NW 20012 Alexis Adams/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5/18 12 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park Crematory Riverdale, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. B910 Silver Hill Rd., Suitland, MD. 20746 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between hock, or heart fails Immediate Cause (Final Onset and Death Physician/ 10apo disease or condition Medical resulting in death) Examiner nteriosat Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last -trans and Due to (or as a consequence of): the burial attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by fanation 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has page 2 performe 2 6 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔼 No ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after deatl To the Funeral Director: completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifie 1 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Currifying Number Practice of the basis of my investigation, in my opinion, death occurred at the time, date and place, and due to the neurols and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vore MD 4203 Queensbury Ad Hyactsville MD 20781 De Date filed (Month, Day, Year) 32. Registrar's Signature State 2 2 2012

DHMH 17 Rev 7/2009

Registrar

				pe or Print in E						e.
		1	For State Registrar	State of Maryland	-	artment of F tificate of L			giene Reg. No. 20	12 17741
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Denise Louise	Addison				2. Date of De Month	1 2 2 2 0 1	3. Time of Death 12 20 p M
	Examin	er	4a. Facility Name (if not institution, give stre 7817 Michele Dr	eet and number)		4b. City, Town, or Hyatt	Location of De	eath	4c. County of D	eath Georges
	Funeral Director			7. Age (In yrs. Ia 5 4	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M			Birthplace (State or Foreign Country) DC
	aryland a-f show ified at	ector	Usual Residence of Decedent 10a, State MD 10b. County Prince	Georges 10c. City	, Town or Lo	Hyattsv	ille			10d. Inside City Limits 1 ፟፟፟፟ 1 Yes 2 □ No
	with the M 23a or 28 ust be not	Funeral Director	10e. Street and Number Chele I	or.		10f. Zip Code 2078	15		10g. Citizen of What	Country?
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	[출	11. Marital Status 1 Never Married 2X Married 3 Widowed 4 Divorced	R. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.		Was Decedent of H f Yes, specify Cuba 1 Yes 2 No	ın, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		merican Indian, /hite, etc. Lack
Maryland 21215-0036	thin 72 hour ene. than "natu he Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)		(Give	dent's Usual Occup kind of work done O NOT use retired) Data I	during most of v	working	16b. Kind of Busine	
and 2	d be filed within 7 Mental Hygiene. Irked other than tic event, the M	To Be	17. Eather's Name (First, Middle, Last) Elmer Meadows				18. Mother's Hat	Name (First, Middle, tie Lose	, Maiden Surname) ewell	
	12 should alth and Me 27 is mar r traumati		19a. Informant's Name/Relationship (Type Alvin Addison/I	Print) Husband	190 8 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Address (Street Miche	and Number or Le Dr.	Rural Route Number Hyatts	er, City or Town, State VIIIe, M	20785
Baltimore,	Page 1 and nent of Hea ant: If item ary or othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		emeterv. crer	osition (Name of matory or other place ake Crei	n. 5	/22/12	20c. Location - City Beltsvi	y or Town, State 11e, MD.
Balti	permit. Departr Imports any inju		21. Signature of Funeral Service Licensee	y Chavis vd.Dunki	III. F.S rk, MD20754					
	Pnysician/		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the death cause on each line.		er the mode of dyir	19, such as card	diac or respiratory a	rrest,	Approximate Interval Between Onset and Death
and a	Medical Examiner		resulting in death)	Due to (or as a consequ						
	ted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlving Cause (Disease or iinjury that initiated events c.	Due to (or as a consequ	ience of):					
0	e be executed ysician and e burial-transif	lical Ex	resulting in death) Last	Due to (or as a consequ	ience of):					
Box 68760	law requires that the death certificate be executed has been signed by the attending physician and a 2 should be detached for use as the burial-transit	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 23 in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome of pregna 1 Live Birth 2 Feta 4 Pregnant at time of c	aldeath 3	Ectopic pregnan Other (specify)	су		23d. Date o Month	f delivery Day Year
P.O.	es that the signed by 1 1 be detach	d by Phy	Part II. Other significant conditions cont	ributing to death but not res	ulting in the	underlying cause g	ven in Part I.		_	te to the cause of death?
Division of Vital Records,	The law require cate has been si page 2 should I	omplete						24a. Was auto perf	formed? deat	e autopsy findings available to completion of cause of th? Yes 2 \sum No
tal B	sician: The law certificate has b irector, page 2 s	Be	25. Was case referred to medical examiner?	spital:		Oth	or:	Check only one)		
of Vi	ng Physi fter this c	ate: To	1 ☐ Yes 2 ☐ No 27. Mann Death 1 ☐ Natural 5 ☐ Pending	1 Inpatient 2 28a. Date of injury (Month, Day, Year)	28b. Time of injury	ont 3 DOA 28c. Inju	4 ∐ Nursin ry at k?	28d. Describe	how injury occurred	Specify)
ivision	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director.	Certificate:	2 Accident 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, st		Yes 2 No	28f. Location	(Street and Number o	r Rural Route Number,
Ω	e Hospital 124 hours e Funeral	Medical	(Check 2 Medical Examine	ian: To the best of my know r: On the basis of examination Practioner: To the best of m	n and/or inves	stigation, in my opin	ion, death occur	red at the time, date	and place, and due to	the cause(s) and manner stated.
_		2	29b. Signature and title of certifier			29c. Licens		3.1	29d. Date signed (M	
	10		30. Name and address of person who cor			Print)		9110	5/16/) IND 20137
	Sta	ite	KEVA GIU 31, Date filed (Month, Day, Year)	32. Registrar's Figna	ulu900	in Aw	Dlub	2400	river dal) Jeily Only,
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ETHEL ADAMS

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	Examin	er	Doctors Communi		1		4b. City, Town, o	r Location I ham	or Death		George's				
	Funeral		5. Social Security Number 6. S	Sex 7. Age		st birthday)	If Under 1 Year Months Days	If Unde Hours	r 24 Hrs. Min.	8. Date of Bir (Month, Da	th ay, Year)	9. Birthplace (State or Foreign Country)			
	Director		Usual Residence of Decedent	□ M 2 🖾 F	72	Yrs.				July 2	8, 193				
	yland -f shov ed at	ctor	10a. State 10b. County	0		r, Town or Lo anham	cation						10d. Inside City Limi		
	he Mar or 28a notifi	i.	Maryland Prince 10e. Street and Number	George's	Ъ		10f. Zip Code				10g. Citize	en of What Co			
	s 23a ust be	Funeral	9211 4th Street				207					JSA			
	r death or item iiner n		11. Marital Status 1 ☐ Never Married 2 🄀 Married	12. Was Decedent E Armed Forces? 1 Yes 2 🔀		13. \	Was Decedent of H If Yes, specify Cub	lispanic Oi an, Mexica	rigin? (Spe an, Puerto	ecify Yes or No- Rican, etc.)	14	I. Race - Ame Black, White			
21215-0036	ırs afte ıral", c I Exam	Completed by	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	NO		1 Yes 2 X No	Specify	y:		Sp	pecify: Wh:	ite		
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and	e filed ntal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last) Edward Thomas Jo					1		e (First, Middle Jouise '					
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "hatural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (19b. Mailii	ng Address (Street						o Code)		
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Baltimore,	permit. Page 1 Department of Important: If i any injury or once.		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Licer		Tar	22	2. Name and Addre	ss of Faci	lity		4739	Balt:	imore Aven	ue	
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mus.	Physician/		shock, or heart failure. List only Immediate Cause (Final	one cause on each line	e.				-	ilur			Interval Between Onset and Death		
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120	icate be exe g physician a as the burial-	Medic		d											
Box 68760	eath certifica attending pl	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 montps?		2 Feta	al death 3	Ectopic pregnar	ю			20	3d. Date of de	blivery Day Year		
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Division of Vital Records,	l or Attendi after death. Director: A d in by the f	ertif	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine				reet, factory, office			28f. Location City or To	(Street and own, State)	Number or Ru	ural Route Number,		
Ö	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but the funeral director, page 2.	Medical Certificate:	29a, Certifier 1 Certifying Pr	ysician: To the best o	f my know	ledge, death	occurred at the tir	ne, date ar	nd place, a	and due to the	cause(s) and	d manner as s	tated	1-1-1	
	the Ho	Med	(Check 2 Medical Exa only one) 3 Certifying No	miner: On the basis of urse Practitioner: To the	examinatione best of a	n and/or inve	e, death occurred a	the time,	date and p	at the time, date lace, and due to	the cause(s	and manner	as stated.	tated.	
	To the within 5 comple		29b. Signature and title of certifier		į	M	29c. Licen		0611			signed (Mon:			
	pa		30. Name and address of person who	completed cause of	death (Iten	n 23a) (Type,	Print)			7				_	
			SAMUEL AS: 31. Date filed (Month, Day, Year)	FAW, ML		3118	600d	Luci	K 1	LOAD,	LANA	AM 1	ND 2070	0	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 10e, per FH, g928 6-5-12 sm State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Year Month 1205 PM Physician/ James Edward Beeler 05 22 2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washing ton 14507 Heavenly Acres Ridge Road Hancock 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 232-62-7566 1 🕅 M 2 🗆 F WV **Director** 12/06/1939 72 Yrs. Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified and once. 10a. State Director 1 Yes 2 No MD Washington Hancock 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Funeral 21750 14507 Heavenly Acres Ridge Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces?

1 X Yes 2 No Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Supervisor Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) မ Edith Viola Pritchard Henry Cyrus Beeler, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14507 Heavenly Acres Hancock, MD 21750 Betty Diane Beeler/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 05/26/2012 McConnellsburg, PA 4 Donation 5 Other (Specify) Union Cemetery 22. Name and Address of Facility 141 West Main Street Signature of Funeral Service Licens MO0260 Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Cardio myopathy years disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant a Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. .23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 💢 Probably 4 ☐ Unknown Myo cardial Infanction Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? Obstructive Pulmonary 24a Was an performed? Yes 2 No 1 Yes 2 No after death.

Director: After this certificate 26. Place of Death (Check only one) 25. Was case referred to medica Certificate: To Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 27. Manner of Death injury 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number R115203 5/23/ 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 747 Northern Are Hagerstown MD 21742 Barbara A. Spencer, CANP 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 5 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** A M 2012 Maxine K. Beizer May 14, 6:10 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Landow House Rockville If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12/03/1916 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🖾 F 95 Connecticut 049-22-2434 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 □Yes 2 No Director MD Rockville Montgomery 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 1799 East Jefferson Street, Apt. 302 20852 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ∐Yes 2**K** No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 2 White 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 12 should be fi Ralph Kolodney Bess Levy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 40 Pages 1 and 2 ment of Health a ant: If item 27 is ury or other trai 5406 Goldsboro Road Bethesda, MD 20817 Robert Beizer / Son Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Page Department o Important: If any injury or 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 05/18/2012 Falls Church, VA National Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Fune Sentice Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, smooth or learn failure. List only one cause on each line. 5130 Wisconsin Ave. NW Washington, DC 20016 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Endocarditis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cardiomyopathy Due to (or as a consequence of): death certificate be executed use as the burial-trans Exami Hypertension and Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical signed by the attending I IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) □Yes 2X No 9 Unknown 9 Unknowi Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Atrial Fibrillation, Congestive Heart Failure 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 🗆 No 1 □ Yes 2 XNo 1 ☐ Yes Attending Physician; 25. Was case referred to medical examiner? Assisted Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Living Hospital: 1 ∐Yes 2 📆 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral I. 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? (Month, Day, Year) Injury 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide [🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1.00 D0057884 May 17, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Damien J. Doyle MD 6095 Marshalee Drive Suite 100 Elkridge, MD 21075

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year,

MAY 18 2012

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essie J. Ballard			te of Maryland											
essie 5. Dallard	1	- For State	ite or iviaryland			of Death		Wichtan			201	2 1774		
Dhyoiois		Registrar 1. Decedent's Name (First, Middle,	Last)		imouto	-			2. Date of Deat	∌g. №o.		3. Time of Death		
Physiciar Medical Examin	4	JESSIE JAMES BA							Month May 14, 2	Day 012	Year	1142 hrs		
AMPLY	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of D										nty of Death			
		2901 South Leisure Wo	orld Boulevard # 1	12		Silver	Spring			Montg	gomery			
Funeral	7	5. Social Security Number 6	6. Sex 7. A	ge (In yrs. la	ast birthday)	If Unde	r 1 Year	If Under 24	Hrs. 8. Date of Bir	th(MM/DD/Y)		thplace (State or		
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	H	Usual Residence of Decedent	/						1 = 1 = 0 /	2300				
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other transmatic event, the Medical Examiner must be notified at once	ᄋ	19a. Informant's Name/Relationshi				-	•		atonsvill					
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Baltimore, permit. Pages 1 an Department of Hee Important: If itee injury or other tr		21. Signature of Funeral Service L	icentee	0.	\/	2. Name and			Snowden E					
	4	23a. Part I. Enter the disease, or c	The	d the death	To not onto	246 N.	Wasr	ungto	n St, Roc	est shock or	heart	Approximate Interval		
Physician //wedicar	Į	failure. List only one cause of	n each line.									Between Onset and		
Examiner												Boust		
			b.	sequence o	1).									
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x 6 th cer ttendi	icia			at time of de	ath 5	Other (Spec	ify)			T				
BOy he death the att	Physician/Med	1 Yes 2 No 9 Unkr	9 OHATOWIT					n n n	On Did to	-	antributa ta	the cause of death?		
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Division of Vital ppital or Attending Physician: ours after death. teral Director: After this certif filled in by the funeral director.	<u> </u>	27. Manner of Death	28a. Date of Ir (Month, Day	njury ,Year)	28b. Time	of Injury 2		at Work?	28d. Describe	how injury oc	curred			
ion ttendi leath. tor:	탏	1 V Natural 5 Pendil 2 Accident Invest	igation					s 2 No						
Division tal or Attendi rs after death. al Director: A led in by the fi	띭	3 Suicide 6 Could	not be 28e. Place of	Injury - At he	ome, farm, s	treet, factory,	office bui	lding, etc.	28f. Location (3 or Town, S		ımber or Ru	ural Route Number, City		
Divis	Certification:	4 Homicide determ	(6,660))											
8 4 5 2		(ysicien: To the best of niner:On the basis of ex	my knowled	ge, death oc	curred at the	time, date	e and place, death occurr	and due to the caused at the time date.	se(s) and mar	nner as stat	ed. ne cause(s)		
To the within .To the comple	Medical	one) 2 Medicel Exem 29b. Signature and title of certifier	and manner state				License					onth, Day, Year)		
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		Yumili (Wit)	nau, MI							1, 10,				
		30. Name and address of person v Pamela E. Southall, MI				900 W Ba	ltimore	Street B	altimore, MD 2	1223				
Sta	ote.	31. Date filed (Month, Day, Year)	32 Regist	rar's Signat					,	_				
Sta Registr	_	NAY 182	012 Censu	NA	. pa	-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

#5 Per FH G929 7/11/2012 Jh
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg No. 2 0 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Month Linda Christina Johnson Brown 20, May 0611 hrs. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hyattsville 1331 Ray Road Prince Georges If Under 1 Year If Under 24 Hrs. 9267=47-7662 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F July 7, 1961 Months 267-47-7762 50 Yrs Ocala, Florida **Director** Usual Residence of Decedent show 10b. County 10a. State with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland Hyattsville Prince Georges 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 20782 1331 Rav Road United States items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc 0 þ 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 72 hours after 1 Yes 2 No Specify. Specify: Black 'natural", Completed 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry

District of Columbia (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Dept.of Human Services 4 years Human Resource Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ည Lillie Nathanie1 Johnson Mae Lewis Thomas traumatic 19a. Informant's Name/Relationship (Type, Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Celester Demallfus Brown, Jr. 1331 Ray Road; Hyattsville, Maryland 20782 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 'n =ö 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 2012 Brentwood, Maryland ignatu f Funeral Se 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician Metastasis Breast Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 Yes 2 X No Day Year Pregnant at time of death Month 1 ☐ Yes 2 ☐ 9 ☐ Unknown the Unknown þ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 s autopsy page ; performed? Yes 2 No the Hospital or Attending Physician: The certificate rector, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 **X** No Hospital: Other: ည 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify After this of 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 X Natural (Month, Day, Year) 5 Pendina in 24 hours area when the Funeral Director Affine Funeral Director Affined in by the funeral filled in by the funeral fil Accident 1 🗌 Yes 2 🗌 No Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and 0 29d. Date signed (Month, Day, Year) May 27, 2012 0 Ac060937 Name and address of person who completed cause of death (Item 23a) (Type, Print) 9200 Basil Court; Suite 200 Largo, Maryland

Registrar

Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 8:16 A DORIS **FAYE** BALDERSON May 20 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death McCready Memorial Hospital Crisfield Somerset 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min. 1 M 2 🔀 F Mary Land 0670711937 74 Director 214-36-5974 Usual Residence of Decedent ntal Hygiene. 3d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Maryland Somerset Crisfield 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3294 Sackertown Road 21817 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 🙀 Married þ Yes 2 X No 1 Tes 2 No Specify. If Yes, Give Specify.White 3 Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Machine Operator and Mental Hygien is marked other th Cutlery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Orland Marshall Margaret Ward and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bobby Balderson (Husband) permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t 3294 Sackertown Road - Crisfield, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St. Pauls Cemetery 05/24/2012 Marion Station, MD 21. Signature of Juneral Service License 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St.-Crisfield, MD Robert H. Bradshaw Jr 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MYOCARDIAL INFARCTION CUTE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ASCV D Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami attending physician and for use as the burial-transi that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🖟 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hospital or Attending Physician: The law page 2 s autopsy performed? Yes 2 No certificate 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 1 X Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af 2 No Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical l 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 48098 12 l Highway Crisfield, MD 21817 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vijay Karumbunathan, M.D., - Date filed (Month State

DHMH 17 Rev 7/2009

Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

of Vital

Division

11111 A A KAJA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death ISRUN S Month 11 P M Physician/ EI een Mae 2012 May Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner olumbia Cheneral Howard Counti Howard If Under 24 Hrs. 9. Birthplace (State or F 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 508-28-5161 Usual Residence of Dece 1 □ M 2 屎 F **Director** May 12, 1925 87 Nebraska show 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits notified at Director 28a-f 1 🗆 Yes 2 🙀 No MD Columbia Howard 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a United States 6500 Freetown Road #108 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Black, White, etc. ò þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White Completed 3 - Widowed 4 - Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Emma Wagner John Suaden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6500 Freetown Road #108 Columbia, Maryland 21044 Donald J. Bruns/husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, Ardent Cremation Svc. 5/18/2012 Hanover, Maryland 22. Name and Address of FacilityHarry H. Witzke's Family FH Inc. Sign the re of Funeral Service Licer 4112 Old Columbia Pike Ellicott City, MD 21043 Homas Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Pulmonary Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** hyonic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last and burial-tra Due to (or as a consequence of) attending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?

1 Yes 2 No

9 Unknown Month Day Year Pregnant at time of death igned by the at be detached f signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 10 24a Was an 24 hours after death.

Funeral Director. After this certificate has to remain the page 2.8. performed or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Medical Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Inpatient Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at 5 Pending work? 1 Yes 2 No Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 3064 legistrar's Signatu<mark>d</mark> State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State Registrar	Plea	State of		d / Depa	artment of tificate of	Health		Iental Hyตุ	giene		17749		
Physiciar		1. Decedent's Nam	e (First, Middle	,						2. Date of Dea Month May		2Ŏ12	3. Time of Death 11:35P M		
Medica Examine		4a. Facility Name (if		give street and numb	er)		4b. City, Town,	or Location		k			's		
Funeral Director		5. Social Security N 008-28-1 Usual Residence	1574	6. Sex 7	. Age (In yrs. Ia	75 Yrs.	If Under 1 Year Months Day		Min.	8. Date of Birt (Month, Day 01/23/	, Year)	Count	ry)		
faryland Ba-f show tified at	ector	10a. State	10b. County St. M	ary's		y, Town or Lo	n Park			•		1	0d. Inside City Limits		
with the N 23a or 2a st be no	Funeral Director	10e. Street and Nur 45874 S1	mber				10f. Zip Code	653			Country) Canada 10d. Inside City Limits 1				
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permit. Depart Import any inj		21. Signature of Fu	neral Sevice L	Echolo TI	#M0081	22	2. Name and Ado	ress of Faci	lity B	rinsfie	ld-Ech	nols F.	H., P.A.		
Physician/ Medical		23a. Part 1. Enter shock, or hea Immediate Cause disease or condition resulting in death)	ırt failure. List c (Final	complications that ca inly one cause on eac aabuse to (a	h line.	L Hoa	er the mode of d	_		or respiratory arr	est,	_	Interval Between		
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tal or Atters as after des al Directoried in by the	ıl Certificate;	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	not be 28e. Place of	of Injury - At ho g, etc. (Specify		reet, factory, offic	e		28f. Location (S City or Tow		umber or Rural	Route Number,		
the Hospi nin 24 hou the Funer Tpletely fill	Medical	(Check 2 only one)	2 Medical E 3 Certifying	xaminer: On the basis Nurse Practitioner:	of examination	n and/or inves	stigation, in my op	inion, death	occurred a	t the time, date a	nd place, an	d due to the cau	use(s) and manner stated.		
To To To Con		29b. Signature and	title of certifier	m	0			nse number	57	4		_			
10 8,			//	who completed cause	900 Me:	rchant	s Lane.	St #2	05, 1	Leonardt	own,	MD 206	50		
State Registra		31 Date filed (Mon		32 Po	gistrar's Signa	ture/par/									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ava Sevilla Bartges Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Western Maryland Health System Cumber land Allegany Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Hours **Director** 578-54-5404 1 □ M 2 🏋 F 89 Usual Residence of Decedent Jan. 18, 1923 Romney, WV permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director WV 1 Yes 2 X No Hampshire Augusta 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 135 Sol Shanholtz Rd. 26704-0092 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify. Specify.White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Practical Nurse Medicine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Chloe Savilla Smith Albert VanMetter Raines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15055 Alphin Ln. Culpeper, VA 22701 Danny Bartges (son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation cemetery, crematory or other place) 3 Removal from State 4 Donation 5 Other (Specify) May 25, 2012 Romney, WV Ebenezer Cemetery mature o uperal Service 22. Name and Address of Facility Scarpelli Funeral Home, P. A. 108 Yirginia Ave. Cumberland, MD 21502 her the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myucardial disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or injury attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the at d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by pe Acute Renal Failure 1 Tes 2 No 3 Probably 4 Unknown completely filled in by the funeral director, page 2 should Chronic Kidney Diseace 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No has within 24 hours after death.

To the Funeral Director: After this certificate 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending injury 1 Natural Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

the 9

State Registrar (Check

only one)

Christopher S. Vagnoni M.D

Year 5

(Item 23a) (Type, Print)

Registrar's Sign

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

925 Setan Drive, Cumberland, MD 21502

29d. Date signed (Month, Day, Year)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Month Physician/ BARRETT VIRGINIA MAY 6:15 2012 Α Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner WASHINGTON WILLIAMSPORT HOMEWOOD AT WILLIAMSPORT If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** WEST VIRGINIA Hours 1 □ M 2 💢 88 4/4/1924 Director 234-36-7210 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County be notified at Director W٧ HEDGESVILLE BERKELEY 1 ☐ Yes XX No 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 0 USA 1014 OAK GROVE SCHOOL ROAD 25427 Funeral items 23a death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever in U.S. Armed Forces Black White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatin þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE If Yes. Give 3 ¥ Widowed 4 □ Divorced Completed Year or Dates. 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) GARMENT FACTORY Elementary/Seconday (0-12) College (1-4 or 5+) DRAPER 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname VIRGINIA BELL LUTTRELL ည SAMUEL PUFFENBURGER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1014 OAK GROVE SCHOOL ROAD, HEDGESVILLE, WV 25427 MARY ANN HEDGES/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) MAY 29, _____2012 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CENTRAL CHAPEL CEMETERY HEDGESVILLE, WV Signature of Funeral Service Licenses 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, MARTINSBURG, WV 25402 327 W. KING ST., Approximate interval Between 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause of each line. stance 2 Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Litter or denying Cause (Disease or injury Examine D e to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death Unknown er significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed 1 Yes 2 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital: 1 🗌 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 DOA Nursing Home $5 \square$ Residence $6 \square$ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral o 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury work? 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Sulcide 4 ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Ocertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signati

DHMH 17 Rev 7/2009

Registrar

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Mame and

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 27^{pay} 05^{Month} 2012 10:25 A M Robert Franklin Bull Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Carroll Carroll Lutheran Village Health Care Westminster If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**∑** M 2 □ F Days Hours COMPTY) b3[%]14/1928 219-22-3802 Director Usual Residence of Decedent filed within 72 nous accessival Hygiene.
ed other than "natural", or items 23a or 28a-f shows: event, the Medical Examiner must be notified at. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Westminster 1 Yes 2 No MD Carroll 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21158 205 St. Mark Way, Apt. 121 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1948—
If Yes, Give Black, White, etc. 1 Never Married 2 Married ۾ Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced 1950 White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Data Base Administrator Black and Decker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) of Health and Mental He files of Health and Mental He item 27 is marked of ျှ Laura Redmond other traumatic Paul Bull 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 St. Mark Way, Apt. 121, Westminster, MD 21158 Patricia Bull/wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/30/2012 |Hampstead, MD Carroll Cremation Signature of Funeral Service License 22. Name and Address of Facilit Pritts Funeral Home and Chapel 21157 412 Washington Road, Westminster, MD 23a. Page. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Demante disease or condition Medical resulting in death) Examiner dispase JONON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ysician and e burial-transit law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical the attending phys IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No g Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? page Hospital or Attending Physician: The 2 N 1 Yes Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral of 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 🔀 Natural 5 Pending work' within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes 2 🗌 No Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29d. Date signed (Month, Day, Year) 51705 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminster ANGURIYA DR Malcolm 31. Date filed (Month, Day, Year) State JUN 0 5 2012 Registrar

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Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 30 hours after death	To the Fundan Director. After this certificate has been signed by the attending physician and

			Please Type or Prin					-	_	jible.	
			For State of Ma	aryland	•	artment of H		1ental Hyg	giene		
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of D	eath	2. Date of Dea	Reg. No. 2	112	17/53
	Physicia	_	John Thomas Carstens					Month MAY	Day	Year 20/2	3. Time of Death 750 A M
	Medic Examin	aı	4a. Facility Name (if not institution, give street and number)			4b. City, Town, or I	Location of Death	7'1'17	4c. County		1501
			Doctors Community Hospital			Lanham			Princ	e Geo	rge's
	Funeral			(In yrs. last	birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day		9. Birthpl Countr	ace (State or Foreign ry)
	Director		215-38-5227 1 ☑ M 2 ☐ F Usual Residence of Decedent	71	Yrs.			April 2	24, 1941	Brook	lyn, NY
	show dat	tor	10a. State 10b. County	10c. City, T	own or Lo	cation				10	od. Inside City Limits
	Mary 28a-f otifie	irec	MD Prince George's	Colle	ege P						1 🔀 Yes 2 🗌 No
	th the 3a or t be n	alD	10e. Street and Number			10f. Zip Code			10g. Citizen of		
	ath wi	Funeral Director	9020 49th Avenue 11. Marital Status 12. Was Decedent E	ver in U.S.	13. \	20740 Was Decedent of His	spanic Origin? (Spe	cify Yes or No-	14. Rac	USA ce - America	
9	or its	by F	Armed Forces? 1 □ Never Married 2 ☒ Married 1 ☒ Yes 2 □			Was Decedent of His f Yes, specify Cuban		Rican, etc.)	Bla	ck, White, e	
21215-0036	urs af tural", al Exa		3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.		0	1 Yes 2 X No			Specify	Wn	ite
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ylaı	Ild be Menta narked	입	Joseph William Carstens				Hazel Mai				
Maryland	shou h and 7 is m traum	7	19a. Informant's Name/Relationship (Type, Print)	1		Address (Street al					ode)
e,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		Jean F. Carstens / Wife 20a. Method of Disposition	20b. Plac	e of Dispo	49th Aven		ege Par	20c. Location		wn, State
moi	age 1 ent of nt: If i		1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	1		natory or other place eaven Ceme		1/2012	Silver	Sprir	o MD
Baltimore,	permit. F Departm Importa any inju		21. Signature of Funeral Service Licensee	Juace		2. Name and Address		7/2012			ore Avenue
Ω	8 3 E 5	1 1	Log Lichent							ville	, MD 20781
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	the death. [Do not ente	er the mode of dying	, such as cardiac o	or respiratory arr	est,		Approximate Interval Between Onset and Death
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	- 00 =	— I	resulting in death) Last Due to (or as a	Re	0.0	ra tor	4 La	dur	0		
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the but	by Physician/Medica	d		74	. 0()	1) -	11911			
89	certifi ending use a	an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome 1 ☐ Live Right			☐ Ectopic pregnancy	J		23d. Da	ate of delive	ry
Bo	death ne atte ied for	sicis	in the past 12 months? 1 Yes 2 No 9 Unknown			Other (specify)			Mo	onth I	Day Year
P.O.	at the d by th	Phy	Part II. Other significant conditions contributing to death b	ut not resulti	ing in the u	underlying cause give	en in Part I.	23e. Did to	bacco use conf	ribute to the	e cause of death?
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ord	requires been sign	Completed	ryper lens 10	^				24a. Was a		Were autop	sy findings available
Sec.	he law te has	omb						autop perfo	rmed?	prior to con death? 1 \sum Yes 2	npletion of cause of
al	ian: T	Be C	25. Was case referred to medical examiner?		_	26. Pla	ice of Death (Checi		-		
Ξ	hysic this ce al dire	은	1 Yes 2 No Hospital: 1 Ninpatie		R/Outpatie	nt 3 DOA Othe	4 ☐ Nursing Ho				
Division of Vital Records,	al or Attending P s after death. I Director: After t d in by the funera	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day)		injury	work		28d. Describe h	ow injury occuri	ea	
Sio	Atten	rtific	3 Suicide 6 Could not be 28e. Place of Inju	ry - At home	e, farm, str	eet, factory, office		28f. Location (S		er or Rural	Route Number,
Σ	tal or		4 Homiciae determined building, etc	:. (Specify)		_		City or Tow	n, State)		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2.	Medical	29a. Certifier (Check (kamination a	nd/or inves	tigation, in my opinio	n, death occurred a	t the time, date a	nd place, and du	ie to the cau	se(s) and manner stated.
	o the lithin 2 or the lomple	Ĭ	only one) 3 Certifying Nurse Practitioner: To the 29b. Signature and title of practition	e best of my	knowledge	, death occurred at the			ne cause(s) and i 29d. Date signe		
	12.		* Omale Ougat	116	}-	D52	500		5/13	5/12	
	(A)		30. Name and address of person who completed cause of do	eath (Item 23	3a) (Type, I				, , ,		
			DR Fozia Abdulwah	abe	,81	118 Cara	dLuck	Rd, Lo	anham	mol	20706
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 16. 2012 Marie W. Copher May 4:10 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Collington Episcopal Lifecare Comm. Prince George's Mitchellville If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 018-20-6173 Hours Min (Month, Day, Year) Director 1 M 2 X F July 28, 1914 Virginia 28a-f show at 10c. City, Town or Location 10d. Inside City Limits Director notified Maryland Prince George's Mitchellville 1 X Yes 2 No the items 23a or ner must be n 10e. Street and Number 10f. Zip Code 'n 10g. Citizen of What Country? by Funeral 10450 Lottsford Road 20721 United States 11. Marital Status Was Decedent Ever in LLS 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, event, the Medical Examiner Armed Forces? Black, White, etc. ō 1 Never Married 2 Married and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 African 1 Yes 2 No Specify If Yes Give "natural" Completed 3 X Widowed 4 Divorced Specify Year or Dates American 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Hygiene. life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Social Worker Supervisor Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ? is marked o ပ John W. White Sr. Gracie Vaughan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Annie L. Crocker - Sister 13603 Missoula Court Upper Marlboro, Md. 20774 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otl once, 20c. Location - City or Town, State May Date 24 Page 1 cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Cemetery 2012 Landover, Maryland 21. Signature of Funeral Service Licensee Stewart Funeral Home, Inc. 22. Name and Address of Facility John 4001 Benning Road, NE Washington, DC 20019 M00560 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 days Immediate Cause (Final disease or condition Physician Septicemia Medical resulting in death) Due to (or as a consequence of): Examiner Urinary Tract Infection days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Exam Cause (Disease or injury that initiated events resulting in death) Last Dehydration 1 week and Due to (or as a consequence of): use as the burialthe attending physician Physician/Medical requires that the death certificate be Senile Dementia Division of Vital Records, P.O. Box 68760 years IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No for Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ page 2 should be Completed 1 Yes 2 No 3 Probably 4 Unknown been s 24a. Was an 24b. Were autopsy findings available this certificate has prior to completion of cause of death?

1 Yes 2 No autopsy performed? Hospital or Attending Physician: The 1 ☐ Yes 2 🖾 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 🔀 Nursing Home 5 🗌 Residence 6 🗎 Other (Specify) 1 🗌 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at After 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending death. Investigation
6 Could not be 1 Yes 2 🗆 No Accident the Funeral Director: Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the comple

31. Date filed (Month, Day, Year) Registrar

title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Schissler

29b. Signature a

Peter M.

7500 Greenway Ctr. Dr.

D22780

Greenbelt, Md.

29d. Date signed (Month, Day, Year)

20770

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Control Contro				State of Maryland	/ Depa	artment of H	ealth and N	nental Hyg	jiene	
Prince P					Cer	tificate of D	eath			2 17755
Part Court				1. Decedent's Name (First, Middle, Last) NAVADA OAVI 2			2. Date of Dea Month		3. Time of Death 2. 3. A M	
Second Second Promotion Colors Co	-			4a. Facility Name (if not institution, give street and number)		4b. City, Town, or l	Location of Death		4c. County of Dea	ith
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23a Part 1. Enter the disease, or complications that caused the death; Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause Final Responsibility (or cause) or each intermediate Cause Final Responsibility (or cause) (or as a consequence of): Due to (or as a consequence of): Due to (or a	imo	Page ment c ant: If ury or		I LANDUNIAI 2 LI CITEINALION 3 LI REINOVALIONI SLATE			20	12,	Landover,	Maryland
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OS ON COL STATE OF THE PROPERTY OF THE PROPERT		ecutec and I-trans	Exan	Cause (Disease or injury that initiated events c.	nce of):				<u> </u>	
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				31. Date filed (Month, Day, Year) 32. Registrar's Signatur						

12-03945 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. John Anthony Dyson State of Maryland / Department of Health and Mental Hygiene 2012 17756 1- For State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Day May 24, 2012 JOHN **Medical Examiner** ANTHONY DYSON 1147 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince George's Clinton 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Director Months Days 219-84-4723 **½** M 2 F 43 AUG.14,1968

		Usual Residence of	f Decedent											
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with page 2	Funeral	11. Marital Status		12. Was Decedent	Ever in U.S	S				gin? (Specify			14. Race - Ameri	can Indian, Black,
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Baltimore, permit. Pages 1 at Department of Hee Important: If ite			neral Service Licens	-	•		22. Name	and Addres	s of Facility	RAYMO	OND.	FIIN	I. SERV	VICE, P.A.
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Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: /	Medical	one) 2	Medical Examiner:	on me basis of exam and manner stated.	ination and	a/or in	vestigation, in	my opinior	n, death occ	curred at the ti	me, date a	and plac	e, and due to the	cause(s)
	Σ	29b. Signature and	tive of certifier	/				29c. Licens	se number			29d. D	ate signed (Mon	th, Day, Year)
10 gr		7				\		O.C.	M.E.			May	25, 2012	
	ŀ	30. Name and addre	ess of person who co	empleted cause of de	eath (Item 2	(3a)								
OCME	J	Mary G. Rip	//	uty Chief Medic	•		900 W. E	Baltimore	e Street.	Baltimore	MD 21	223		
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AMEND ITEM#11,19a,20b, perFH, G928,6/11/2012, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Mont 5 Physician/ 2012 9:16 P Clarence Thomas Ferguson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ellicott City Lighthouse Senior Living Howard Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Country) 236-32-3263 **Director** 1 🖾 M 2 🗆 F 3-10-1924 88 WV Usual Residence of Decedent show 10a State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f Prince Wlliam VA Woodbridge 1

Yes 2 □ No 10e. Street and Number ms 23a or must be n 10f. Zip Code 10g. Citizen of What Country? Funeral 4344 Granby Rd 22193 United States items death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "nature" any injury or other traumatic. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates 3 XWidowed 4 ☐ Divorced Specify: African American Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Military Policeman U.S. Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Dubois T. Ferguson Annie K. Coles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony T. Mitchell/stepson 12907 Canoe Ct. Fort Washington, MD 20744 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place; 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 6/4/2012 native of Puperal Service Librases 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Alzheiners Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) and as the burial-tran Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE nse (23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 🗌 No Yes 2 No 1 Yes • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 X No ည Assisted 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Living 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitione. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) D47447 May 21, 2012 who completed cause of death (Item 23a) (Type, Print) 104 30. Name and address of perso

Registrar

DHMH 17 Rev 06-2011

State

6334 Cedar Lane #103 Columbia, MD

21044

MID

32.

Registrar's Signature

Andrew Lazris,
31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 's Name (First, Middle, Last) Physician/ 448 20 Year Medical 4a. Facility Name (if not institution, give street 4c. Coun 4b. City, Town, or Location of Death Examiner emple last birthday If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year, 948 Washingon DC Director Usual Residence of Decedent items 23a or 28a-f shov ner must be notified at 10c. City, Town or Location 10b. 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Ses 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Marital Status 14. Race - American Indian. Armed Forces? "natural", or iter edical Examiner 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates. Specify Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medicall once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) I Ransportation Be Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Avenue Temple Hills MD 20748 Bakbana Gree 20c. Location - City or Town, 20a. Method of Disposition 20b. Place of Disposition (Name of Date Rurial 2 Cremation 3 Removal from State 24-2012 4 Donation 5 Other (Specify) Rock-Hall WISEMON FUNERCI Home 52 Alexandria Ferry Rd Clinton lub 20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final ₽nysician/ corr Ta disease or condition Medical resulting in death) Due to (as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying HTI -transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last burialphysician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death n signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 - Homicide Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certife 29d. Date signed (Month, Day, Year) 119 mp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #510

DHMH 17 Rev 7/2009

State Registrar merson

31. Date filed (Month, Day, Year)

Oron

5801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mayth GRAY RAMON 2012 0435 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Prince Georges General Hospital If Under 1 If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdav) 8 Date of Birth **Funeral** Hours Min (Month, Day, Year) 578 06 9235 1 M 2 D F **Director** 41 WASHINGTON D.C. Usual Residence of Decedent June 13 1970 28a-f show 10a, State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Prince Georges Landover 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20785 U.S.A. 3403 Dodge Park Road items Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 Never Married 2 M Married þ 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+) Private Service Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Gray Unknown Debbie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3403 Dodge Park Road #101, Landover Maryland 20735 Department of Health Important: If item 27 any injury or other to once. Cheryl W. Gray, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 5 ☐ Other (Specify) 4 Donation Glenwood Cemetery 5/29/2012 Washington, D.C uneral Service Licensee 22. Name and Address of Facility HALL BROTHERS FUNERAL HOME 6 Florida Avenue, N.W., Washington, D.C. 20001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final CARDIAC Ph. sician/ FATAL disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner CHRONIC Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ig physician and as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 1 Yes 2 Lg Unknown Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHRONIC OBSTRUCTIVE PULMONARY Records, 1 Yes 2 No 3 Probably 4 Unknown OBSTRUCTIVE SLEEP APNEA 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No certificate has HYPERTENSION 2 No 1 Yes To the Hospital or Attending Physician: Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Tes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer (Month, Day, Year) 1X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Limit Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tle of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHEVERLY MD 20785 AKRAS 3001 HOSFITAL 31. Date filed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5 Day 19 2012 1:45 P M Doris M. Geppert Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ellicott City 12077 Windsor Moss Howard Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Davs Hours Director 209-32-1236 1 M 2 X F 8-12-1940 PA 71 Usual Residence of Decedent 23a or 28a-f show ist be notified at the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Howard Ellicott City 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? by Funeral Page 1 and 2 should be filed within 72 hours after death with iment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a 21042 United States must 12077 Windsor Moss er than "natural", or items the Medical Examiner mu 11 Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White 3 Vidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Aide Education Ith and Mental Hygien 27 is marked other the r traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Helena Hugney Arthur F. Magnuson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 10517 Old Court Road Granite MD 21163 Wendy J. Geppert/daugh.-in-law 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 05/25/2012 Louis Cem Clarksville, MD 21. Si√natu ∵of Funeral Servi ⊁ Lio 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition Physician AMYOTROPIC LATERAL SCLEROSIS Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to jor as a consequence of Cause (Disease or injury that initiated events and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as the F FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death detached the 1 ☐ Yes 2 ☐ Unknown been signed k should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director. After this certificate has etely filled in by the funeral director, page 2 s autopsy perform Yes 2 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🖊 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Hosp within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

30

State Registrar 31. Date filed (Month, Day,

8325

E

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JACKSON

D0063166

ROAD

GUILFORD

MAY

COLUMBIA

2012 -

MD 21046

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Physician/ 14 Day Richard Hurst, Jr. 2012 May 17:32 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Age (In vrs. last birthday) **Funeral** Min. Months Days Hours MAY 17,2012 217-28-1956 **Director** 1 🗷 M 2 🗆 F 81 Yrs. Oct. 17 1930 Virginia Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location the Maryland Examiner must be notified at Director 1 X Yes 2 No Rockville Montgomery MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral 106 Charles Street items 23a 20850 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No 1944 and Mental Hygiene. is marked other than "natural", or by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give Completed 3 Widowed 4 Divorced 1962 Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Richard L. Hurst Carrie permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20850 Evalene Hurst / Wife 106 Charles Street, Rockville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rockville, Maryland 05/18/12 Parklawn Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Muriel H. Barber Funeral Home 1020 O. Box 5038, Laytonsville, Maryland 20882 23a. Part 1. Effect he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between
Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final myocardial acirte Physician/ disease or condition Medical resulting in death) Due to (or as a consequency of): **Examiner** Commary ar YEAVS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has it autopsy performed? certificate 25. Was case referred to medica 26. Place of Death (Check only one) Be 1 Yes 2 □ No Other: ျှ 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 IDOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer injury 1 🔀 Natural 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month. Day. Year) 13x1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) fredical Center Drive, Rockville, 1901 William Dooley, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 6=10 AM thony umes 2017 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Adventist Washington lakoma Par lontgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. 9. Birthplace (State or Foreign **Funeral** Hours Min **Director** 579-80-1727 56 ashington Usual Residence of Decedent 28a-f show 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 112 Yes 2 No MD Prince George's <u>Hyattsville</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6500 Riggs Road 20783 United States within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2K No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the N College (1-4 or 5+) Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ျ Joan Briscoe Damon Humes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DC 20011 5510 Blair Rd N.E. Washington, <u>Joan Jefferson/ Mother</u> 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) 05-21-12 Fort Lincoln Cemetery Brentwood, MD 22. Name and Address of Facility Fort Linccln Funeral Home 21. Signature of Funeral Service Lice Bladensburg Rd. Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Phylician. erebrovasc disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury esterolemia Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi percho that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death the : g 🗌 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy this certificate 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner?

1 Yes 2 No director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ ER/Outpatient 3 DOA 1 Inpatient 24 28a. Date of injury (Month, Day, Year) After thi funeral . Mann of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury Natural work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completed filled in by the ft Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D006742

State Registrar Carroll

Avenue

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2012 Physician/ William Leslie Hannum 16, 4:55 A M May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 11805 Chantilly Lane Mitchellville Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours (Month, Day, Year) **Director** 212-24-4511 83 1 ፟፟ M 2 □ F Apr 12, 1929 Washington, DC Usual Residence of Deced 28a-f show 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Prince George's 1X Yes 2 No Mitchellville 10e. Street and Number 10g. Citizen of What Country? by Funeral 20721 11805 Chantilly Lane USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 🖾 Yes 2 🗌 No NAVY Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 1952-1956 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Builder Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Hiram Leslie Hannum Janie E. Forney permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn L. Hannum - Wife 11805 Chantilly Lane, Mitchellville, MD 20721 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 5/21/2012 Brentwood, Maryland 21. Signature of Funeral Service Licensee 4739 Baltimore Ave. 22. Name and Address of Facility Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death years Immediate Cause (Final Physician/ Congestive heart failure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Emphysema 10 years Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events as the burial-transit Aortic valve stenosis 5 years Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Cor pulmonale 2 years IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy Month Day Year Pregnant at time of death Other (specify) 4 Pregnant : 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an completely filled in by the funeral director, page 2. certificate has autopsy performed? Yes 2 X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 2 🕱 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 X Natural 2 Accider injury 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifi 5-18-2012

State Registrar

1(4)

68760

Box (

P.O.

Division of Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death HENSON Physician/ 7:47 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPKINS BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign (Month, Day, Year) 1945 Country) 579-58-3689 Director 1 **X**M 2 □ F 66 September 25. Washington, D.C 28a-f show J Hygiene. I other than "natural", or items 23a or 28a-1 snovent, the Medical Examiner must be notified at 10h Count 10c. City, Town or Location the Maryland 10d. Inside City Limits Director District of Columbia Washington 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 1809 - 23rd Street, S. E.; Apt. 231-A 20020 United States 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 **Black** 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Specify. Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade Deputy U.S. Marshal Marshal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည Isaac Henson Dorothy **Williams** 1 and 2 should by Health and Mei 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3915 "S" Street, S.E.; Washington, D.C. 20020 Marvin Allen Henson (Brother) 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of I important: If it any injury or of once. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glenwood Cemetery May 26,2012 Washington, D.C. 21. Signature of Foneral Services MO1421 22 Name and Address of Facility R. N. Horton Company Morticians, Inc.:600 Kennedy Street.N.W.:Washington.D.C.20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician SEPSUS disease or condition resulting in death) Medical Due to (or as a consequence of) Examine OBSTRUCTION Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Examine The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? β Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performe certificate Yes 2 No 1 ☐ Yes 2 ☐ No i or Attending Physician: after death. funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Matural Natural 5 Pending after death.

Director: Aft
d in by the fu 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No M Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospitai 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) RES-000 May 19, 2012 Name and address of person who completed cause of death (Item 23a) (Type, Print) 1800 ORLEANS STREET BALTIMORE MD 21287 HERYVY M.D. 31. Date filed (Month, Day, Year,

Registrar

		Please Type or Print in Black Indelible Ink.	Ensure All Copie	es Are Legible	
22N# 18	-	State of Maryland / Department of He State of Maryland / Department of He Certificate of De		ygiene Reg. No. 201	2 17765
Physicia		1. Decedent's Name (First, Middle, Last) I sene 12 Hamilton	2. Date of D Month MAY	eath Dav Year	3. Time of Death 2 12:35A M
Medic Examin		4a. Facility Name (if not institution, give street and number) CHAS.CO.NURSING & REHAB.CENTER LA PLAT	ocation of Death	4c. County of Dea	ith
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year II	If Under 24 Hrs. 8 Date of B	irth 9. Bi	rthplace (State or Foreign ountry) NNSYLVANIA
	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	SEP.2	1,1910 PE.	10d. Inside City Limits
the Mary or 28a-f e notifier	Funeral Director	MD CHARLES HUGHESVILLE 10e. Street and Number 10f. Zip Code		10g. Citizen of What C	1 🗆 Yes 🗷 🐪 No
ath with time 23a must be	uneral	7 480 SERENITY DRIVE 2063 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hisps		U. S.	Α.
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 3 ☑ No If Yes, Give Year or Dates.	eanic Origin? (Specify Yes or No Mexican, Puerto Rican, etc.) Specify:	Diaon, Will	
21215-0036 within 72 hours after giene. er than "natural", o	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done duri		16b. Kind of Business	
1 212 d within tygiene. ther the nt, the N	Be Cor	12 PIPE ORGANIST		LUTHERAN	CHURCH
Maryland: 2 should be filed ith and Mental Hyy 27 is marked oth traumatic event.	To E	17. Father's Name (First, Middle, Last) CHARLES REIGHART	8. Mother's Name (First, Middle ANNA AUCOU		
re, Mar and 2 shou Health and tem 27 is m		19a. Informant's Name/Relationship (Type, Print) KAREN NALE / DAUGHTER 19b. Mailing Address (Street and 7480 SERENITY)			
imore, Page 1 an ment of He ant: If iter ury or othe		20a. Method of Disposition 1 ☐ Burial 22 ★ cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	MAY Date	20c. Location - City of	r Town, State
Baltimore, permit. Page 1 and Department of Here Important: If item any injury or othe once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of	29, 2012 of Facility RAYMOND	ALEXANDI	VICE,P.A.
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, s		ırrest,	MD 20646 Approximate Interval Between
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	At Failu	re	Onset and Death
Examiner	ier	Sequentially list conditions b. Africal from	Mation		
ecuted and I-transit	xamine	cause. Enter Underlying Cause (Disease or injury that initiated events c.			
60 ate be exe physician a	dical E	resulting in death) Last Due to (or as a consequence of): d.			
ision of Vital Records, P.O. Box 68760 Attending Physician: The law requires that the death certificate be executed ar death sector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of de Month	elivery Day Year
ords, P.O. wrequires that the speen signed by the standard be detact.	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given Portice Stenosis, Demonto a CV	1A	tobacco use contribute to	
Division of Vital Records, tal or Attending Physician: The law requires rs after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be a constant of the funeral director.	Completed	Failure to thrive, Anaemia, Hypert	ension 24a. Was	s an 24b. Were au	itopsy findings available completion of cause of
ital Rec iician: The la certificate ha	Be Con	Chronic Tenas in support of Place 25. Was case referred to medical	per 1 ☐ Yes e of Death (Check only one)	ormed? death?	V
of Vita Physici r this cer	မ	examiner? Hospital: Other:	4 Nursing Home 5 Res	idence 6 Other (Spec	cify)
ion of tending F death. tor; After the funer	Certificate:	1 Natural 5 ☐ Pending (Month, Day, Year) injury work? 2 ☐ Accident Investigation M 1 ☐ Yes	s 2 No	now injury occurred	<u></u>
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		(Street and Number or Ru wn, State)	ral Route Number,
Div To the Hospital or within 24 hours afte To the Funeral Div	Medical	29a. Certifier (Check (Check only one) (Check one) (Check only one) (Check only one) (Check only one) (Check one) (Chec	death occurred at the time, date	and place, and due to the	cause(s) and manner stated
om with		29b. Signature and title of certifier 29c. License nu 7	1199	29d. Date signed (Mont	h, Day, Year)
- 4 sm		30 Name and address of person who completed cause of death (Item 23a) (Type, Print) about 10 10 10 10 10 10 10 10 10 10 10 10 10	Blud Giler	Busnie	mD
Stat Registra	e ir	31. Date filed (Mooth, Day, Year) 32. Registrar's lignature 33. Registrar's lignature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2012 Year Month MAY **Physician** DORIS LINDA HOMAN 11:55 p^V /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 200 Manor Ave. Kent Chestertown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Jan 11 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Months Hours 1 ☐ M 2 🗓 F 429-72-3193 Virginia 72 1940 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b Count 28a-f show r than "natural", or items 23a or 28a-f sho 1 XYes 2 No Director Kent Chestertown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 200 Manor Ave. 21620 U.S.A. r death Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐ XNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than College (1-4or 5+) Elementary/Secondary (0-12) Administrative Assistant Hospital 4 permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg Important: If item 27 is marked any Injury or other transportant. traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be David Spicer Ella Rita Neil 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert Homan (husband) 200 Manor Ave. Chestertown, MD. 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5/31/12 Galena, MD. Galena Cemetery 4 Donation 5 ☐ Other (Specify) olympral Service Leanse ^{22. Name and Address of Facility} Galena Funeral Home of Stephen L. Sc 118 West Cross St. Galena, MD. 21635 M00510 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heap failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Caus (Final disease o co ion resulting i ath) ADENOCARCINOMA WITH LIVER METAS-Physician /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine transit-To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): physician as the burial-t O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown ٣. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown GRANULOMATOSIS RENAL DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 26. Place of Death (Check onl one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Injury 1 🗷 Natural 5 Pending s after death.

I Director After in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide filled within 24 hours a Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

DHMH 17 Rev 1/2001

D0041587

Chestertown, MD. 21620

5-29-2012

A Nobel my

122 Speer Rd.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Helen A. Noble, M.D.

JUN 0 5 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death Raymond Newton Hovermale Medical Month 0.5 103 acility Name (if not institution, give street and number)
Meritus Medical Center **Examiner** 4b. City, Town, or Location of Death County of Death Washington Hagerstown **Funeral** . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 215-34-2834 8. Date of Birth 9. Birthplace (State or Foreign Director 1 🛣 M 2 🗆 F 2-27-1938 Country) or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must he notified as "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 10c. City, Town or Location MD 10d. Inside City Limits Washington Hagerstown 1 Yes 2X No 10e. Street and Number 10f. Zip Code Funeral 10g. Citizen of What Country? 11314 Manse Road 21740 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1956-15 Yes 2 No 1960 14. Race - American Indian, 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 Black. White, etc. 3 Divorced If Yes, Give Year or Dates. Completed 1 ☐ Yes 2 X No Specify white traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th grade trucking company driver Be Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) June Llaine McAllister Raymond Kenneth Hovermale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11314 Manse Road Hagerstown, MD 21740 Shirley A. Hovermale wife 20a. Method of Disposition 20b. Place of Disposition (Name of 1 KBurial 2 Cremation 3 Removal from State June Date 1. 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Cedar Lawn Cem. Hagerstown, MD 2012 Signature of Funeral Serv Donald Edwin Thompson Funeral Home, Inc Spring Part 1. Enter the disease Part 1. Enter the disease, of complications that conshock, or heart failure. List only one cause on earth sed the deal. Do not enter Immediate Cause (Final Physician, disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the attending physician and that initiated events resulting in death) Last Completed by Physician/Medical IF FEMALE 23b. Was decedent pregnant 23c. If yes, outcome in the past 12 months?

1 Yes 2 No 1 Live Birth
4 Pregnant
9 Unknown Live Birth 3 Ectopic pregnancy
5 Other (specify) 23d. Date of delivery Fetal death 1 Yes 2 9 Unknown Pregnant at time of death Month Day Year Division of Vital Records, P.O. Part II. Other significant conditions confilibuting resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Be 25. Was case referred to medical 1 Yes 2 🗌 No examiner? ျှ 1 Yes 2 No ER/Outpatient 3 DOA filled in by the funeral 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at ☐ Natural 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ertifier completely nly on ed at the time, date and place, and due to the cause(s) and manner as stated 29b. signature and title of certifie 10gm 31. Date filed (Month, Day, State

Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) 2012 **Physician** naves 995 4:01 A MON ים /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** en Year If Under 24 Hrs. orrol (37P) If Under Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 95 1 M 2 ☐ F Yrs. Maryland 11/14/1916 Director 215-07-1424 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir then "natural", or iteme 23s or 28e-f show the Medical Examiner must be notified at Westminster 1 Yes 2 No Carroll Maryland Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 21157 612 David Ave. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White þ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Standard Oil Greasemaker/Chemist 12 t. Peges 1 and 2 should be filed v rement of Heelth and Mental Hygis rtant: if item 27 is marked other t njury or other traumatic event, to 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Gertrude Basel George R. Haas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 612 David Ave., Westminster, MD 21157 Noma Pearl Haas/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: if eny injury or once. Carroll Cremation Inc. 06/01/2012 Hampstead, Maryland 21. Signature of Funeral Service Licensee Prites Afunerally Home and Chapel, P.A. 16 412 Washington Rd., Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** (Orona rons /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760 attending physicien Certification; To Be Completed by Physician/Medical for use es the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) within 24 hours effer death.

To the Funerei Director: After this certificate hes been signed by the seminates tilled in by the funeral director, page 2 should be detached. Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. evenisi 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Tyes 1 Inpatient 2 YER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

10gm

State

Registrar DHMH 17 Rev 1/2001

To the

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

295 Stua 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a (Type, Print)

29c. License number

29d Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MAY WILLIAM C. **JOHNSON** ĬŎ 2012 9:55 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CAPITOL HEIGHTS PG 1514 PACIFIC AVE Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 578-70-0204 Hours Director 1 💢 M 2 🗆 F 10/2/1950 DC 61 Usual Residence of Decedent 28a-f shov or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director PG CAPITOL HEIGHTS 1 Xyes 2 □ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20743 514 PACIFIC hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. X Yes Yes, Give ģ 1 Never Married 2 Narried Maryland 21215-0036 1 ☐ Yes 2X No Specify: BLACK 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) PRINTER GOVERNMENT and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P permit. Page 1 and 2 should be Department of Health and Menl Important; If item 27 is marke any injury or other traumatic e GLORIA T. BUTLER WILLIAM C. JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRENDA JOHNSON/WIFE 1514 PACIFIC AVE, CAPITOL HEIGHTS, MD 20743 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, LINCOLN MEMORIAL CEMETERY 17,2012 4 Donation 5 Other (Specify) SUITLAND, MD 21. Signature of Funeral Service Lice POPE FUNERAL HOMES, P.A. 22. Name and Address of Facility 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ercho Vesau Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Dille to for as a nonewquenes of that, ledding to immedicause. Enter Underlying Cause (Disease or injury that initiated events Exami requires that the death certificate be executed -tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hou

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completely fi 29a. Certifier (Check gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature a 29d. Date signed (Month. Day, Year 00055120

Registrar

State

1328 Southern

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ess of person who completed cause of death (Item 23a) (Type, Print)

82. Registrar's Signature

MD

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31. Date filed (Month, Day, Year)

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ PHILLIP **JOHNSON** CARL 7:24 P May 20. 2012 . Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Crisfield Somerset McCready Memorial Hospital Social Security Number Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🔀 M 2 🗆 Months Days Hours Min 219-34-4146 11770371915 **Director** 96 Maryland Usual Residence of Decedent or 28a-f show iral", or items 23a or 28a-f shor Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Crisfield Somerset Maryland 1 Yes 2X No 10e Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral 21817 U.S.A. 26584 Mariners Road 11. Marital Status 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. White Specify: þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾No Specify important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exan If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Assembly Food Processing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Mollie Ennis Frank D. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 so of Health a item 27 i P. O. Box 423 - Crisfield, MD 21817 Alvinia Lynn Nelson (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Sunnyridge Mem. Park | 05/24/2012 Crisfield, MD Signature of Puneral Service Live 22. Name and Address of Facility
Bradshaw & Sons Funeral Home Robert H. Bradshaw, 306 W. Main St.-Crisfield, MD 21817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each lin Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami burial-transi Due to (or as a consequence of) Physician/Medical that the death certificate be iding p IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? jo Year ☐ Pregnant at time of death ☐ Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign Records, 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? 1 ☐ Yes 2 ☑ No 24 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2-INO Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide
Homicide Investigation the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2180

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Division of Vital

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 0 | 2 for State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 5 2.40 AM bent Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. Social Security Number **Funeral** Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 212-44-1908 Months Director 1 M 2 🗆 F 67 06/13/1944 Washington DC Usual Residence of Dec 28a-f show 10a. State 10b. County must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2 🗓 No MD Anne Arundel ShadySide 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral within 72 hours after death with 20764 USA 4722 Idlewilde Road items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give þ 1 ☐ Never Married 2X Married Black, White, etc. "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed Specify. Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Steamfitter Local 602 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Theodore L. King Mildred Delores Ralph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4722 Idlewilde Road ShadySide, MD 20764 Patsy L. King Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State Browns Cemetery 4 Donation 5 Other (Specify) 05/15/2012 Sabillasville,MD 21. Signature of Faneral Service Lice 22. Name and Address of Facility 12 Ridgely Ave Annapolis,MD 21401 Hardesty Funeral Home 23a. Part 1. Enter ble disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory prest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset 7 d Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a cons, guence, of): **Examiner** Esquentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death Month Year 2 No 9 Unknown a Hinknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Completed by neoctobil rubable 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 01110 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has performed? Yes 2 No 2 No 1 Yes filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examine ? Hospital 2 🗌 No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Hame 5 Residence 6 Other (Specify, 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred ☐ Natural ☐ Accident 5 \square Pending iniury work 3/292 2 🗶 No. Walkin Investigation 51 CHILL AM 1 🗌 Yes Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Jumber or Rural Route Number, City or Town, State) 4722 Idlewilde Rd 4 Homicide determined building, etc. (Specify) nome within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29b. Signature and title of certifier 29c. License number 30. Name and address of person who co ated cause of death (Item 23a) (Type, Print) 10+ Ю 445 Annapolis

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 20 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month May Physician/ 201 Evelyn Virginia Knox 6:20 P Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Regional Hospita Prince George's aurel aure 6. Sex If Under Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 399-20-1564 88 1 M 2 XX Director 3/22/1924 NE shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f MD Prince George Bowie 1 🗌 Yes 🕱 No items 23a or ner must be n 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 3901 Corbin Place 20715 USA death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc 0 þ 1 Never Married 2 Married Yes 2**XX**No Yes, Give filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2x XNo Specify White "natural" Completed 3 XXVidowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the 5+ Teacher of Health and Mental Hygier f item 27 is marked other I r other traumatic event, th Music Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Junge Evelyn Carlstrom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Curtis L. Bort 320 Beechmount DR. Hampton, VA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2XXCremation 3 Removal from State Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 5/17/2012 Glen Burnie, Md 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hardesty Funeral Home, P.A. 10 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Arterioscleratic Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of). g physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physiciar Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death for in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy performe 2 No Yes 2 No 1 🗌 Yes or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 X No Other: 2 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Director: After 5 Pending Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and title of certifier 29d. Date ≴igned (Month, Day, Year) 20/2 7300 Van Dusen Road Laurel, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Nicholson

1 6 2012

MD

Laurel

Regional Hospital

20707

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	4	State of Maryland / Department of Health and N	/Jental Hyตุ	giene	
		State Registrar Certificate of Death		Reg. No. 20	2 11115
Physician/ Medica	/	1. Decedent's Name (First, Middle, Last) William Albert Krause	2. Date of Dea Month May	18, 2012	3. Time of Death 7:25 P M
Examine	r	4a. Facility Name (if not institution, give street and number) Laure Regional Hospital 4b. City, Town, or Location of Death Laure	,	4c. County of Dea	th George's
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birtl (Month, Day	n 9. Bi	rthplace (State or Foreign
Director		Usual Residence of Decedent			shington, DC
aryland a-f sho lied at	2010	10a. State 10b. County 10c. City, Town or Location Maryland Prince George's Beltsville			10d. Inside City Limits 1 Yes 2 □ No
or 288	=	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	
seath with the Maryland items 23a or 28a-f shore must be notified at Enneral Director	llera -	11803 N Lincoln Avenue 20705		USA	
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imord Page 1 anent of H ant. If ite ury or of	ľ	1 ☐ Burial 2 🗵 Cremation 3 ☐ Removal from State cemetery, crematory or other place)	Date	20c. Location - City or	·
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- Physician/		snock, or heart failure. List only one cause on each line.		:S1,	Approximate Interval Between Onset and Death
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DIVISION OT VITAI RECORDS, P.O. BOX 68 /60 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and sompletely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certificate: To Be Completed by PhysicianI/Medical Exami	1	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, an Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, an Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, an Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, an Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and the model of th	the time, date and	d place, and due to the	cause(s) and manner stated.
		29b. Signature and title of certifier 29c. License number 10 166 05	2	9d. Date signed (Month	
130	3	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wang Koon, M	D	3/10	/12
State	3	7300 Van Dusen Koad Launel Ma 31. Date filed (Month, Day, Year) 32. Registrar's Signature	arylonz	(20708	
Registrar		MAY 2 2 2012 Jeney D. Janes			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Halen R. Month KOOH TZ &JZAM Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll Hospital Center Westminster 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 215-20-8256 Director 1 DM 2 🔀 F 88 June 16,1923 Maryland or 28a-f shown notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Westminster Maryland Carroll 1 Yes 21 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 123 Hahn Rd. 21157 USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Black, White, etc. ö þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural" Completed 3 Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) i Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Louis Goulden Ida Mae Zurgable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health John Edgar Koontz/Husband 123 Hahn Rd., Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit, Page 1
Department of
Important: If it
any injury or o cemetery, crematory or other place) t Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Mem Gardens 05/30/2012 Finksburg, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Printer After After After 11 Home and Chapel, P.A. Mr. 412 Washington Rd., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) Medical Due to (or as a consequence of): [′] Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): as the burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: nse 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for it 5 Other (specify) Pregnant at time of death Month 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law i within 24 hours after death. To the Funeral Director: After this certificate has b autopsy 1 ☐ Yes 2 ☑ No ☐ Yes 2 1 No 25. Was case referred to medical examiner? Be **Division of Vital** 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 6gm completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 5 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 1013 Edward Lagana 900M Ronald Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1512 Patuxent Manor Road Davidsonville Anne Arundel Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 579-56-4737 1 X M 2 □ F Director 67 Washington, DC 7/27/1944 tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Davidsonville 1 Yes 2 X No Marvland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1512 Patuxent Manor Road 21035 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify onfy highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Printing Typesetter æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file h and Mental H 7 is marked of မ Navarro other traumatic Lagana Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Linda Lagana/Wife 1512 Patuxent Manor Rd., Davidsonville, MD 21035 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Mem'l Garden 5/18/2012 Davidsonville, MD 22. Name and Address of Facility George P. Kalas Funeral Home Euperal Service 21. Signature of 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ ASTOMA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: f yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year the g Unknown g 🗌 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been si Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Oirector: After this certifica completely filled in by the funeral director, Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural 5 Pending 1 Tes 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) etyd cause of death (Item 23a) (Type, Print) Name and address of person who comp Shad 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

MAY 16 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrate D#8perINF, 5/21/12; BMW, McCo Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May Month Day 2012 Year Ludwig 16. 2:50 Henry R. рМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Brooke Grove Rehab. & Nursing Ctr Sandy Spring Montgomery 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Davs June 30, Year 1917 127-10-1472 Director 1 🖾 M 2 🗆 F New York r than "netural", or items 23e or 28e-f show the Medical Evaminer must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17309 Twin Ridge Court 20905 USA 12. Was Decedent Ever in U.S. Armed Forces? 12☑ Yes 2 ☐ No If Yes, Give Year or Dates. WWII Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. <u>م</u> 1 Never Married 2 KMarried within 72 hours after Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) CPA Finance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, should be file and Mental F ဂ Christine Wium Henry Robert Ludwig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Ludwig/Daughter 17309 Twin Ridge Court, Silver Spring, MD 20905 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 s
Department of F
Important: If ite
any injury or ot May Date 21, 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory 2012 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 on Ble CMM 23a. Part 1: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Dysrhythmia Medical Due to (or as a consequence of): Examiner Bradycardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): signed by the ettending physician and id be detached for use as the burlal-transit The lew requires that the deeth certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Anemia Due to (or as a consequence of): Physician/Medical Parkinson's Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physiclen: The lew require within 24 hours after death.

To the Funerel Director, After this certificate has been si completely filled in by the funeral director, page 2 should it. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 21 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physiclen: 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Prijstical: 16 the best of thy individual, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatur@and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 15+1

State Registrar

31. Date filed (Month, Day, Year) MAY 18

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Physicia	ın/	Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year O2.42 here
lical Examii		Stephon Marcel Langley 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	May 17, 2012 0242 hrs
)		1007 Marcy Avenue Apt. 304	Oxon Hill	Prince George's
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)		- 1007 F: Wachingt
Director		578-23-2756 1XM 2 F 19	Yrs. Months Days Hours Min.	August 22, Country D. C.
b	ļ	Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Lo	cation	10d. Inside City Lir
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nyland ta-f sh	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
Baltimore, MD 21215-5-0036 permit. Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Dire	932 Bellevue Street, S. E.	20032	United States
ms 23;	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Pican, etc.) 14. Race - American Indian, Black, White, etc.
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mit. I partme portai	- J	1. Signature of Funer Len Ice Licensee VI 142 2	2. Name and Address of Facility R.	N. Horton Company Mortician
E E E E	3			Street, N.W.; Washington, D.C.
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ital Kecords, P.O. Bo sician: The law requires that the de is certificate has been signed by the irector, page 2 should be detached f	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpat	26 Place of Death (Check	
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VISION OF VITAL RECORDS, P.O. EN or Attending Physician: The law requires that the de flor death. Nirector: After this certificate has been signed by the in by the funeral director, page 2 should be detached f	To Be	examiner? 1 Yes 2 No 1 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 1 Nospital: 1 Inpatient 2 ER/Outpat 2 Ba. Date of Injury (Month, Day, Year) 28a. Place of Injury - At home, farm,	ient 3 DOA Other Nursin Nursin of Injury 28c. Injury at Work? 1 Yes 2 No	ng Home 5 Residence 6 ✔ Other: Scene
Division of Vital Records, P.O. Box 68760, notes that or Attending Physician: The law requires that the death certificate be executed tours after death. After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial - transifiled in by the funeral director, page 2 should be detached for use as the burial - transifiled in by the funeral director, page 2 should be detached for use as the burial - transifiled in by the funeral director.	To Be	examiner? 1 Yes 2 No 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined Could no	ient 3 DOA Other Nursin Nursin of Injury 28c. Injury at Work? 1 Yes 2 No No street, factory, office building, etc.	ng Home 5 Residence 6 Other Scene 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, or Town, State)
LIVISION OF VITAL RECORDS, P.O. Est Boptical or Attending Physician: The law requires that the de n. 24 hours after death. After this certificate has been signed by the letely filled in by the funeral director, page 2 should be detached followed.	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 4 Homicide 28a. Certifier 1 Certifying Physician: To the best of my knowledge, death of the determined (Specify) Hospital: 1 Inpatient 2 ER/Outpat 28b. Time (Month, Day, Year) 28e. Place of Injury - At home, farm, (Specify)	ient 3 DOA Other Nursing of Injury 28c. Injury at Work? 1 Yes 2 No No street, factory, office building, etc.	ng Home 5 Residence 6 ✔ Other Scene 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, or Town, State) d due to the cause(s) and manner as stated
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 4 Homicide Pending Investigation (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time (Month, Day, Year) 28b. Place of Injury - At home, farm, (Specify)	ient 3 DOA Other Nursing of Injury 28c. Injury at Work? 1 Yes 2 No No street, factory, office building, etc.	ng Home 5 Residence 6 ✔ Other Scene 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, or Town, State) d due to the cause(s) and manner as stated

State Registrar

Laron Locke MD.

a filed Month Day Year) 32. Registrar's Signature

OCME

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month Physician/ Leaf Susan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland If Under 1 Year If Under 24 Hrs. . Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 235-82-4927 61 **Director** 1 □ M 2 🗓 F Oct. 5, 1950 WV 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State Examiner must be notified at Director Yes 2 No MD Cumberland Allegany 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ items 23a Funeral US 425 Valley Street 21502 death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 X Married "natural", or p Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White If Yes, Give Year or Dates Specify: Completed 3 Divorced 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Office 12 2 should be filed with h and Mental Hygien 7 is marked other tt Accountant other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Alice CHaney Lester Snyder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21502 of Health a David Leaf, Husband 425 Valley St., Cumberland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ō Department of Important: If any injury or Scarpelli Funeral HOme 5/26/12 Cresaptown, MD ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, P.A. Signatur of Funeral Service 108 Virginia Ave. Cumberland, MD 21502 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final aso Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Due to (or as a consequence of) ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months? 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy Director: After this certificate has Yes or Attending Physician: after death. filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending Investigation Accident Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Hospital 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fi 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 29b. Signature and title of cortified 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day

5

Blanche H. Mavromatis MD. 12502 Willowbrook Rd. Str. 300, Cumberland, MD 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Year Month Physician/ 15 7:43 a.m. Albert Wayne McCleaf Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 17335 <u>Mountain View Road</u> Frederick <u>Emmitsburg</u> . Social Security Number . Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**№**M 2 🗆 Months Hours Min. sep. 1926 220-16-3494 85 Pennsylvania **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho Director MD Frederick Emmitsburg 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17335 Mountain View Road 21727 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1

Yes 2 □ No Black, White, etc 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give Year or Dates. WWII 3 Widowed 4 Divorced Completed and Mental Hygiene.
is marked other than "natural aumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) US Postal Service Rural Carrier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filt Department of Health and Mental I Important: If item 27 is marked c any injury or other traumatic eve ပ Albert William McCleaf Elizabeth Amelia Eiker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Josephine McCleaf wife 17335 Mountain View Rd. Emmitsburg, MD 21727 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Nation 2 Cremation 3 Removal from State Emmitsburg Mem. (5/19/2012 Emmitsburg, MD Cemi. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Myers-Durboraw Funeral Home 22. Name and Address of Facility 210 W. Main St., Emmitsburg, MD R: 1 21727 Rand. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phylician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after dearh.

To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Dause (Disease of imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy
 Other (specify) _____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home Hospital: 5 Residence 6 ☐ Other (Specify) 1 🗌 Yes 2 X No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? iniury 1 X Natural 5 Pending Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🖰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Rractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 0018 30. Name and address properson who completed cause of death (Item 23a) (Type, Print) 21727 31 Set lar Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 2012 Helene Mueller 5:01 Francoise Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Walter Reed National Medical Center Bethesda Montgomery Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1^{Year)} 1925 Sept. Il, Director France 579-88-8276 1 M 2 F 86 or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director DC None Washington, D.C. 1 Yes 2 I No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5601 Chevy Chase Parkway, N.W. 20015 USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Decedent Ever Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hyglene.
7 is marked other than "! Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marcel Chenot Suzanne Babin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 61 Sprague Rd., Scarsdale, NY 10583 permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trau Christine Cohen / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crem. Alexandria, VA. 4 ☐ Donation 5 ☐ Other (Specify) 5-16-2012 21. Signature of Funeral Service Licen 22. Name and Address of Facility DeVol Funeral Home a-M01145 2222 Wisconsin Ave., N.W. Washington, DC 20007 23a. Pm 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Immediat Cause (Final disease or condition resulting in death) Onset and Death Physician/ PNEUMONIA Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ng physician and as the burial transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: asn yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy ō in the past 12 months?
1 ☐ Yes 2 ☒ No Day 5 Other (specify) detached 9 Unknown 9 Unknown <u>о</u>. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physiclan: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I Be 25. Was case referred to medical of Vital 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending Division work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5/15/2012 0101233170 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walter Reed National Medical Center Bethesda, MD 20889 JANINE R. DANKO. 31. Date filed (Month, Day, Year) State MAY 18

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3 Physician/ Zo12 10:15 PM ARGIE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FORRESTVILLE 7511 MARTHA GEORGE S If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F POUNTRY) - INCA 223-64-3481 65 **Director** 0.2 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Director ems 23a or 28a-f shr r must be notified a PRINCE GEORGES ORREST VILLE Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA MARTHA TREET or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. 2 1 Never Married 2 Married ☐ Yes 2 X No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Specify: If Yes, Give Year or Dates Specify: BLACK 3 Widowed 4 Divorced "natural", Completed Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) FEDERAL URSINE ASSISTANTI Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ DALE BARRETT MARTHA EIGH -ARROW 19a. Informant's Name/Relationship (Type, Print) DAVE HTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12401 FARRAL AVENUE CHELTENHAM 20b. Place of Disposition (Name of cemetery, crematory or other p 20a Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State KIVERDALE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) FUNERAL 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 401257 WASHINGTON DC NW 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Onset and Death Immediate Cause (Final Physician/ 40 ars disease or condition resulting in death) / Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying use as the burial-transit Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician d be detached for use as the burial Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death funeral director, page 2 should be detached 1 ☐ Yes ∠ ¥ 9 ☐ Unknown Linknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performe 2 No 1 Yes 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Hospital 1 Tyes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 24 hours after death. Funeral Director: After iniury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and 29c. License number ACO0093]

State Registrar 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. 2 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 4:15 PM M May 25, 2012 Physician/ Anna Mae Minnick Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Homewood at Crumland Farms 8. Date of Birth (Month, Day, Yo Oct. 30, 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday **Funeral** Days Hours 88 Maryland 215-18-1791 1 □ M 2 🗓 F 1923 Director Oct. show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County notified at Director 1 🗆 Yes 2 🎦 No Frederick 28a-f Maryland Frederick 10f. Zip Code 21702 10e. Street and Number 10a. Citizen of What Country? "natural", or items 23a or edical Examiner must be U.S.A. 7404 Willow Road Funeral Page 1 and 2 should be filed within 72 hours after death vment of Health and Mental Hyglene.
sant: If item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner muny or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify White If Yes Give 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Retail Store Sales Clerk Be 18. Mother's Name (First, Middle, Maiden Surname) Orpha Haupt 17. Father's Name (First, Middle, Last, George L. Miller ပ္ 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8802 C Links Bridge Road, Thurmont, MD 21788 Mrs. Marsha L. Opel, daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Zion Lutheran Cemetery May 29, 1 X Burial 2 Cremation 3 Removal from State 2012 Middletown. Department of Important: If any injury or 4 Donation 5 Other (Specify) Signature ²⁸Keeney and Address of Bastord PA_Funeral Home M00255 21701 106 East Church St., Frederick, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final VIVAYALAR DI CAS Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions Due to for as a consequence of; Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the nding p IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 Month Year Day Pregnant at time of death 1 Yes 2 ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed t Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an page 2 s prior to completion of cause of death? performed? 1 Yes 2 No Be (25. Was case referred to medical examiner?

1 Yes 2 26. Place of Death (Check only one) Other ျ Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accider 5 Pending 1 ☐ Yes 2 ☐ No thin 24 hours after death.

the Funeral Director: A
mpletely filled in by the fi Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the F

complete only one) 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

State

1004

Casper Cline, M.D., 300 West 9th Street, Frederick, MD 21701

Registrar's Sign

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) JUN 0 5 2012

D 16428

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🤈 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death MAY MAY Day 201^{Yea} Physician/ 14 9:37 REGINALD MARK NACHREINER, JR. Α Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner OUEEN ANNE'S EMERGENCY CENTER** QUEENSTOWN OUEEN ANNE'S If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, **Funeral** Days Min 395-46-6202 65 1 🕅 M 2 □ F **Director** 06/22/1946 WISCONSIN Usual Residence of Deced 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits at Director iral", or items 23a or 28a-f sl Examiner must be notified 1 ☐ Yes 2 X No GRASONVILLE MD OUEEN ANNE'S 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 906 OYSTER COVE DRIVE 21638 UNITED STATES filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?
1

Yes 2

No If Yes, Give Black, White, etc 1 Never Married 2 XMarried þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 27 is marked other than "natural", traumatic event, the Medical Exar Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) SALESMAN TECHNOLOGY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည REGINALD M. NACHREINER, SR. GRACE MULROONY and 2 should be and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 906 OYSTER COVE DRIVE, GRASONVILLE, MD 21638 ALICE TWING NACHREINER/WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth Page 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 05/16/2012 STEVENSVILLE, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facilit HOME, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ HYPOVOLEMIC SHOCK IMMEDIATE Medical Due to (or as a consequence of Examiner HEMORRHAGE IMMEDIATE Sequentially list conditions, if any leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to or as a consequence of Cause (Disease or injury and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Year Pregnant at time of death Unknown the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown THYROID CANCER Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an THROAT CANCER autopsy performed? death? 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 ☐ Yes 2 🗶 No 2 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Date of injury (Month, Day, Year) 28b. Time of Injury at work?
1 Yes 2 No 28c. 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending injury I Director: A ed in by the f Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours after To the Funeral Direct Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5-15-12 D51639 6+1ms 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 830 CHESAPEAKE DR., KAREN MOFFETT, MDCAMBRIDGE, MD 21613 32. Registrar's Signature 31. Date filed (Month State 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ROBERT E. NELSON III MAY 7 ,2012 8:30 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** FOX CHASE NURSING REHABILITATION SILVER SPRING MONTGOMERY Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days 579-76-4944 Hours (Month, Day, Year) Director 1 X M 2 □ F 08/23/1956 DC 55 or 28a-f show 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10a. State 10d. Inside City Limits Director must be notified 1 Yes 2 No SILVER SPRING MD MONTGOMERY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 2015 EAST-WEST HIGHWAY 20910 US 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 **X** No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc or 1 X Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: BLACK "natural" Completed 3 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) PRIVATE 8TH PORTER 27 is marked other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ROBERT E. NELSON II RHODA E. WALKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Page 1 and 2 sh tment of Health a tant: If item 27 is jury or other tra ZION CHURCH RD., BRANDY STATION, VA 22714 DELORES NELSON-WISE 184 MT. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 17,2012 permit. Page 1
Department of Important: If it any injury or o tment of 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State RIVERDALE, MD RIVERDALE PARK CREMATORY 4 Donation 5 Other (Specify) Funeral Service Licenses 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 7. Enter the disease, or complications the shock, or heart failure. List only one cause on Approximate Interval Between Onset and Death 23a Par 2 Immediate Cause (Final Physicism/ CARDIOPULMONARY ARREST disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner PNEMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): and I-transit Cause (Disease or injury that initiated events resulting in death) Last MULTIPLE SCLEROSIS Due to (or as a consequence of attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ signed by the atter in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? death? 1 Yes Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 XNo မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work?
1 Yes 2 No 5 Pending Accident To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 16,2012 D0067092 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WEIHAN WANG, M.D. 15245 SHADY GROVE ROAD, SILVER SPRING, MD 20850 31. Date filed (Month, Day, Year

DHMH 17 Rev 06-2011

Registrar

MAY 21 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Registrar			Cer	tificate of	Death			Reg. No. Z) 2	11101
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The same of the sa	Examin	er	4a. Facility Name (if not institution,				4b. City, Town, o		of Death		4c. County		
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	th the	a D	10e. Street and Number				10f. Zip Code				10g. Citizen of		-
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336	s after al", c Exam	d by	3 ☐ Widowed 4 ☐ Divorced	ied 1 Yes 2 If Yes, Give Year or Date		1	☐ Yes 2點 No	Specify:			Specify	Blac	t.
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Mar	ge 1 and 2 should be filed within 72 hours after death with the Maryland tr of Health and Mental Hygiene. If filem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	-	19a. Informant's Name/Relationsh			1	ig Address (Street						
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Baltimore, Maryland 21215-0036	Page 1 ment of 1 ant: If its ury or o		1 🖺 Burial 2 🗌 Cremation		tate c	emetery, cren	natory or other pla	ice)		-2012			
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Ö	ital o urs af ral Di								1				
	To the Hospital or Attending Physician: The law requires within 24 hours affer death. To the Funeral Director: Affer this certificate has been sign completely filled in by the funeral director, page 2 should be	Medical	(Check 2 Medical E		of examination	n and/or invest	tigation, in my opir	ion, death o	ccurred at	the time, date a	ınd place, and du	ue to the ca	use(s) and manner stated.
	To the To the Comple	Σ	only one) 3 L. Certifying 29b. Signature and title of certifier	Nurse Practitioner:	lo the best of n	ny knowledge,	death occurred at		ate and pla	ice, and due to t	ne cause(s) and 29d. Date signe		
	4)		16-				1	Mo	46	(05/1	7//-	2
	19		30. Name and address of person	who completed cause	of death (Item	1 23a) (Type, F	Print)	10.	-)-		1		-
	•		Eria Man	blond	750	351	tratt	SP	d.	Clin	ton 1	Ma	20735
	Sta		31. Date filed (Month, Day, Year)	32. Reg	gistrar's Signat	ture							
	Registra	ar	MAY 2 3 2012	Come W	9. 1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ May 3:56 18 ам Douglas M. Odermatt Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Columbia Harmony Hall If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Months Min (Month, Day, Year) Director 014-30-2833 75 1 ★ M 2 | F 10/28/1936 Colorado Usual Residence of Dece f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County at Director must be notified 1 🗌 Yes 2 🎦 No Columbia 28a-f MD Howard 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 20 Funeral with 23a United States 21044 5351 Iron Pen Place death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status ıral", or iten Examiner r Black, White, etc. þ 1 Never Married 2 Married 1X Yes 2 □ No If Yes, Give permit. Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2X No Specify: Specify. White "natural" 3 Widowed 4 Divorced Completed Year or Dates Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical! 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Dept. of Agriculture Entomologist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Adeline Owen Mortimer Raphael Odermatt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5351 Iron Pen Place Columbia, MD Jeanne H. Odermatt - Wife item 2 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of Date Department of H Important: If ite any injury or ot once. cemetery, crematory or other place, 1 🗀 Burial 2🔀 Cremation 3 🗆 Removal from State Hanover, MD 05/21/2012 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crematory 22. Name and Address of Facility Harry H. Witzke's Family . Si matine of Furleyal Service Licensee 4112 Old Columbia Pike Ellicott City, MĎ 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final and Death Physician/ disease or condition resulting in death) Medical Due to (or as a **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami physician and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical as attending IF FEMALE: use 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy 5 Other (specify) for in the past 12 months? Dav Year Month 4 ☐ Pregnant at time of death g ☐ Unknown signed by the a d be detached f 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Assisted 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this funeral (28a. Date of injury (Month, Day, Year) 28c. Injury at Living 27. Manna eath 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending work 1 🗌 Yes 2 🗓 No Investigation Could not be Accident

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 s after death. I Director: Aft filled in by the within 24 hou

To the Fune

completely fi

Baltimore, Maryland 21215-0036

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗀 Certifyi Nurse Practitione st of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title o 29c. License number 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 104

determined

Sulcide

4 \square Homicide

31. Date filed (Month

10298 Baltimore National Pike Ellicott City, MD 21042 Charles Sheehan, MD

State Registrar

Medical

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month. Year 2 Ó Medical Name (if not institution, give street and number) 4a. Facility **Examiner** 4b. City Town, or Location of Death 4c, County of Death 0/15 Age (In yrs. last birthday) If Under Months Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Fore **Funeral** 1 M 2 F Davs Hours Min. (Month, Day, **Director** None Usual Residence of Decedent or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. Qity, Town or Location Examiner must be notified at Director 10d. Inside City Limits 1 Fyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 207 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Was Decedent Ever in U.S. 11. Marital Status 12 14. Race - American Indian, Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 1 🗆 Yes 2 XNo If Yes, Give Specify: 3 - Widowed 4 - Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) N/A College (1-4 or 5+) None None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nce 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 05/24/12 Germantown, Maryland Souls Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Muriel H. Barber Funeral Home Box 5038, <u>Lavtonsville</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each lir Interval Between Doset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) min mo Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? 2 No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 **N**0 မ 1 🗌 Yes 1 Ø Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 - Yes 2 🗌 No Accident Investigation after death Director; 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and ess of person who completed cause of death (Item 23a) (Type, Prin

State Registrar 32

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mont Physician/ 015 Medical acility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** nn 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Hours Min. 9. Birthpla 7. Age (In vrs. **Funeral** 1 - M Days Months Director None Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Injury or other traumatic event, the Medical Examiner must be notified at within 72 hours after death with the Maryland Director 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a Funeral 20 7 3 A and Mental Hygiene. is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. Never Married 2 ☐ Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) None None N/A Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed obpartment of Health and Mental Hyy Important; If item 27 is marked other any injury or other traumatic event, 17. Eather's Name (First, Midgle, Last) Informant's Name/Rela 19b. Mailing Add are eno 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State All Souls Cemetery 05/24/12 Germantown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Muriel H. Barber Funeral Home 20882 Box 5038, Laytonsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ me disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death signed by the aid g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Yes Completed been si should I 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? Yes 2 No page 2 this certificate has ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: Funeral Director: After this certific eted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: ျ 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suiciae 4 ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 within 2 the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) and address of pleted cause of death (Item 23a) (Type, Print

State Registrar strar's Signature

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Fletcher Dane Pres	1- For State Registrar		of Marylan	•	rtment o tificate o		and Men		R	eg. No.	01		177
Physician/ Medical Examine	1. Decedent's Name (F FLETCHER	First, Middle,Last) R DANE PI		S					Date of Dea Month May 28, 2	Day Ye.			of Death 2 hrs
4	4a. Facility Name (if no Queen Anne's	· -		er)		4b. City, Town, Queensto		of Death		4c. County Talbot		n Ar	me's
Funeral Director	5. Social Security Num 214-77-028			Age (In yrs. Ia	ast birthday) Yrs		Year If Under			th(MM/DD/YYYY	g. Birth	place (S	State or
any	Usual Residence of De		VI 2		Town or Locat								ide City Limits
	MARYLAND	QUEEN A	NE'S	CE	NTREVI								es 2 No
the Maryland a nr 28a-f sh tiffied at once Director	10e. Street and Number 316 KIDW	^{er} √ELL AVE.	, CENTR	EVILLE		10f. Zip Code 2161			1	Og. Citizen of W		-	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If litem 27 is marked other than "natural", or items 23a nr 23a-f sho injury nr other traumatic event, the Medical Examiner must be mutified at once. To Be Completed by Funeral Director	11. Marital Status 1 X Never Married 3 Widowed	2 Married 4 Divorced	12. Was Decedor Armed Force 1 Yes f Yes, Give Yeer			is Decedent of es, specify Cul		, Puerto Ri			- Americ e, etc. WHI'		n, Black,
72 hours after all al Examinet	45 December Febru	ation (Specify onl	or Dates:			nt's Usual Occu ost of working	pation (Give	kind of wor		16b. Kind of Bu	siness/In	dustry	
21215-0036 Juid be filed within 72 hour Mental Hygiene marked other than "nature event, the Medical Examo." O Be Completed					STUI	ENT		•		STUD Maiden Surname			
2121: ould be fil ould be fil ould be marked it event,	DARTAN N 19a. Informant's Name	1. PRESGI				-	treet and Nun		al Route Nun	nber, City or Tow		Zip Code	e)
and 2 sho lealth and tem 27 is traumati	JULIE PRES 20a. Method of Dispos	sition				KIDWELL ition (Name of			REVILI Pate	20c. Location		own, Sta	ate
Baltimore, permit. Pages I an Department of Hee Important: If ite	4 Donation 5	Cremation 3 Other Specify:	-	State CHF	CENT			JUN 20	12	STEVEN			
Balt permit Depart Impor injury	21. Signature of Funer	M. 9	10/-		FE 40	LLOWS, B SOUTH	HELFEN LIBER	BEIN TY ST	& NEWI	NAM FUNE NTREVILI	RAL E, M		
Physician Medical	23a. Part I. Enter the of failure. List only Immediate Cause (Fin	one cause on eac	cations that caus h line. Asphyxi a		Do not enter t	he mode of dyi	ng, such as c	ardiac or re	espiratory arre	est, shock, or he	art		timate Interval en Onset and Death
Examiner	or condition resulting	in death)	ue to (or as a co	nsequence of):								
a limer	Sequentially list condi if any, leading to imme cause. Enter Underly (Disease or injury that	ediate Dring Cause	ue to (or as a co	nsequence of									
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'60, ate be ex obysician te burial	IF FEMALE:		AMENDED #2			8a−r,pe	er me,g	3928		23d. Date of	delivery		
). Box 68760, the death certificate by the attending physic chef for use as the burnystician/Mec	23b. Was decedent pre past 12 months?		1 Live birth 4 Pregnant 9 Unknowr	t at time of dea	ath -	tal death her (Specify)	3 Ectopio	c pregnanc	<i>'</i>	Month	Da	y	Year
P.O. res that the signed by the detached by the properties of the		ant conditions	contributing to de	eath but not re	esulting in the u	underlying caus	se given in Pa	art I.	23e. Did to	bacco use contr	_	par.	of death? Unknown
Division of Vital Records, P.O. Box 68760, to the Hospital art Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Directur. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition or to the funeral Completed for use as the burial - transitivation.									24a. Was autop perfor 1 ✓ Yes	sy ped?		mpletion	lings available of cause of 2 No
Vital ysician:	25. Was case referred examiner?		ospital: 1 Inpa	atient 2	ER/Outpatient		Other4			Residence 6	Other:		
n of value Ph	27. Manner of Death	5 Pending	28a. Date of (Month, Da	ay,Year)	28b. Time of I	1	njury at Work			ow injury occurred bag fo		over	head
Division o Hospital nr Attending 24 hours after death. Fibraral Director: Aftered filled in by the fune	2 X Accident 3 Suicide	Investigatio Could not be determined	28e Place o		fd 16: ome, farm, stree ouse/Ro	et, factory, offic	e building, et	c. 28	f. Location (S	Street and Numb tate) 316 K	er or Rura	I Route	Number, City
Division of To the Hospital nr Attending Phy within 24 hours after death. To the Funeral Director. After the completely filled in by the funeral Certification.	29a, Gerundi	ertifyIng Physicla edical Examiner:	un: To the best of On the basis of e	f my knowledg	ge, death occur	red at the time		ace, and du	e to the caus	e(s) and manner	as stated)
To with To com	01		and manner state				ense number			29d. Date sign May 29, 20		h, Day, Y	'ear)
	30. Name and addres	s of person who o	ompleted cause	of death (Item	23a)					<u> </u>			

State 31. Date filed (Month, Day, Year) Registrar

32. Registrar's Signature

900 W. Baltimore Street, Baltimore, MD 21223

Carol H. Allan, MD Assistant Medical Examiner

12-03742 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Patricia Greer Parks 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle, Last) Month Year Parks Patricia Greer 0831 hrs Medical Examiner May 16, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bethesda Montgomery Suburban Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director 214-70-4038 Nov. 12, 1955 1 M 2 X F 56 Washington, DC Usual Residence of Decedent 10d. Inside City Limits any. 10a. State 10b. County 10c. City, Town or Location 1 Yes 2X No 01ney permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Importaot: If item 27 is marked other than "natural", or items 23s or 28s-f sho injury or other traumatic evect, the Medical Examiner must be optified at ooce Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20832 18277 Rolling Meadow Way Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 2 X No Yes Specify: White 4 X Divorced 1 Yes 2 X No specify: 3 Widowed If Yes, Give Yaar 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Government Contracting Accounts Payable Supervisor 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bette L. Reese Be John W. Greer, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Joan L. Ri</u>dgeway/Sister 6126 Edmont Drive, Frederick, MD 21704 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State May 19, 2012 Alexandria, VA Metropolitan Crematory 4 Donation 5 Other Specify. 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 2090 Signature of Funeral Service Licenses Kel 8mx MAR the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. Medical a. Ruptured Aortic Dissection Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause Disease or miury macinitiated Due to (or as a consequence of): events resulting in death) Last Records, P.O. Box 68760, The law requires that the death certificate be executed pue Physician/Medical UNPENDED AMENDED g physician a the burial -23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Fetal death past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy 25. Was case referred to medical of Vital Be examiner? Hospita this No 1 V Yes After 27. Manner of Death Certification: 1 V Natural Pending

Hospital or Atteodiog Physiciao: Division Director: d in by the f To the Hospital
within 24 hours a
To the Fuoeral I

Accident

Suicide

Medical

State

Registrar

Homicide 29a, Certifier 1

29b. Signature and title of certifier Mues 30. Name and address of person who compl-

Ana Rubio MD.

31. Date filed (Month, Day Year)

				1 ✓ Yes 2 N	No 1 Yes	2 No				
referred to medical			26.Place of Death (Check	only one)						
? s 2 No	Hospital: 1 Inpatient 2	P ER/Outpatient 3	DOA Other Nursi	ng Home 5 Reside	ence 6 Other:					
Death S Pending ent Investigat	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe how inj	be how injury occurred					
de 6 Could not determine	be 28e. Place of Injury - At	home, farm, street, facto	ory, office building, etc.	28f. Location (Street a or Town, State)	and Number or Rural R	Route Number, City				
Medical Examine	lan: To the best of my knowle r:On the basis of examination and manner stated.	and/or investigation, in		at the time, date and pl	ace, and due to the cau					
e and title of certifier			29c, License number	29d.	Date signed (Month, E	Day, Year)				
netz'			O.C.M.E.	Ma	y 17, 2012					
d address of person who	completed cause of death (Ite	m 23a)								
bio MD. Assista	nt Medical Examiner	900 W. Baltimore	e Street, Baltimore, M	D 21223						
MAY 18 20	32 Registrar's Signa	5. parl	?.							
	,	ORIGINAL		DCM	E					

Death

Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 'a eneco Physician/ May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death MON 8. Date of Birth (Month, Day, Year) Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Hours Director 40 217-22-5909 1 XM 2 - F 11/19/1971 Guatemala ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the <u>Medical Examiner must be notified at</u> 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring Montgomery MD 1 ☐ Yes 2 No 10g. Citizen of What Country?
Guatemala 10e. Street and Number 10f. Zip Code 3109 Street Funeral Kayson 20906 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Guatemalan Completed by Baltimore, Maryland 21215-0036 If Yes, Give White 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Former Marble Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Maria Pacheco Ortelia Paraiso 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Concha Pacheco/Wife 3109 Kayson Street Silver Spring, Md 20906 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Gate of Heaven 5/19/2012 Silver Spring, Md 4 Donation 5 Other (Specify 21. Signature of Funeral Serv PHILIP OF RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) ENOCArditis Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and loompletely filled in by the funeral director, page 2 should he defend attending physician and attending physician and die for use as the burief transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day □ Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 🗌 No 1 🗌 Yes Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) မူ 1 ☐ Yes 2 D No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature and title of 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Scionetino MRISTOPHER 31. Date filed (Month, Day, Year) State MAY 18 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and	d Mental Hygiene	١,
			Registrar Certificate of Death	Reg. No. 2012 1779	-1
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year O 1.23 A M N N N N N N N N N N N N	
	Medic	al	HAROLD FOST 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of De		
	Examin	er	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De University of Maryvand Medical Center Baltimore	eath 4c. County of Death	
-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H		7
	Director		215-84-6532 1X M 2 G F 48 Yrs. Months Days Hours M	in. (Month, Day, Year) Country) 11/29/1963 MD	
	D WO		Usual Residence of Decedent	10d. Inside City Limits	_
	rrylan I-f sh ied a	cto	MD Worcester Ocean City	1 Tyes 2 N	
	r 282 notif	Direction 1	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?	
	vith th	al	14502 Coastal Hwy. 21842	USA	
	eath v	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	(Specify Yes or No- 14 Race - American Indian	_
9	or it	by F		Diddity Whitely dear	
8	urs a tural" al Exa	Completed	3 Widowed 4 Divorced Year or Dates.	Specify: white	_
5	72 ho "nai ledica	息	15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of ville. DO NOT use retired)	working 16b. Kind of Business/Industry	
12	ithin ene. r thar	ပ္ပ	Elementary/Secondary (0-12) College (1-4 or 5+) Manager	Hospitality	
0	Hygi other	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	Name (First, Middle, Maiden Surname)	
lan	d be f denta irked tic ev	욘	Harold W. Post, Jr. Judit	h Ann Siefken	
lany	should and N is ma auma			Rural Route Number, City or Town, State, Zip Code)	
≥.	ealth m 27			y., Ocean City, MD 21842	
Baltimore, Maryland 21215-0036	t of H If ite or otl		20a. Method of Disposition 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State	
tim	t. Pag tmen rtant: njury			/16/12 Millsboro, DE	
Bal	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.			Burbage Funeral Home ., Berlin, MD 21811	
-		Н	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card		
	Ph_sician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	Interval Between Onset and Death	
	Medical		disease or condition resulting in death) a. Due to (or as a consequence of):		\dashv
	Examiner				
	_ +	ine	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause: Enter Unide lying		
	cuted	Examiner	Cause (Disease or injury that initiated events c.		_
_	ate be executed hysician and the burial-transit	dical E	resulting in death) Last Due to (or as a consequence of):		
760	cate b physi s the l	edic	d		
687	eath certifica attending p d for use as t		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	23d. Date of delivery	Į
Box	eath d for	icia	in the past 12 months? 1 Ves 2 No 4 Pregnant at time of death 5 Other (specify)	Month Day Year	
о. П	the d by the tache	hys	9 🗆 Unknown 9 🗀 Unknown		_
P.0.	requires that the des been signed by the s should be detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?	
ds	equire sen si nould	ted	Hapatanenal Syndrame	1 Yes 2 No 3 Probably 4 Unknow	
CO	has by	Completed by	Portal Gastropathy	24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?	
Re	: The cate I		Hemotherax	1 Yes 2 No	_
ita	sician certifi recto	m	25. Was case referred to medical examiner? 1 Yes 2 No Other: 1 Proposition: 2 FB/Outpatient 3 DOA Other:		-
of V	Attending Physician; The la sr death. ector: After this certificate he by the funeral director, page	은 :a	1 Elipatient 2 ER/Outpatient 3 DOA 4 Nursin 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at	ng Home 5 ☐ Residence 6 ☐ Other (Specify) 28d, Describe how injury occurred	_
n C	nding ath. ". Afte e fun	icat	1 Natural 5 Pending (Month, Day, Year) injury work? 2 Accident Investigation M 1 Yes 2 No	· ·	
Division of Vital Records,	Atte	Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)	
Ö	ital or irs aft al Dir lled in		building, etc. (opeany)	Oily of Town, State)	- 1
	Hospi 4 hou Funer tely fil	Medical	29a. Certifier (Check (ted.
	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Ĭ	only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and 29b. Signature and title of certifier 29c. License number	nd place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)	
	≓≥ ¥%		187189224		
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2120)	03/13/2016	
17:	N5			ay Williams	
Ě	Sta		31. Date filed (Month PalyYer) Q 2010 32. Agistrar's Signature		
	Registra	ar	MAI I 2012 James B. Jakes		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Year Carlotta Jean Parks 5:55 a^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Holy Cross Hospital Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours Country Director 579-86-1452 1 M 2 K F 56 1955 11 13 DC 28a-f shov 10a. State the Maryland 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 X Yes 2 ☐ No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? with 1 items 23a Funeral 2700 Barker Street 20910 United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. er than "natural", or iter the Medical Examiner þ 1 Never Married 2 Married Maryland 21215-0036 filed within 72 hours after 1 Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) Military al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Retirement Residence 4yrs. Communications event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ige 1 and 2 should be fil nt of Health and Mental :: If item 27 is marked ည John Joseph Parr, Jr. Jessie Mae Prue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carlton Veazy/Friend 9606 Stoney Brook Dr. Rensington MD 20895 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Page 1 20c. Location - City or Town, State 1 🖰 Burial 2 🗆 Cremation 3 🗆 Removal from State injury or Department Important: I any injury o 4 Donation 5 Other (Specify) Harmony Memorial 5-19-2012 Landover, Maryland permit. Signature of Funeral Service 22. Name and Address of Facility John T. Rhines Funeral Home 3005 12th Street NE Washington DC 20017 Dart 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Ph, sician/ Bilateral Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Stare IV Kidney Disease Sequentially list conditions Examine Due to (or se a consequence of if any leading to immediate cause. Enter Underlying burial-transit Cause (Disease or injury that initiated events Metabolic Encephalopathy and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months?
1 Yes 2 No Day Month Pregnant at time of death 5 Other (specify) Year the g Unknown 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? 1 Yes 2 No this certificate Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 🗓 No ည 1 ₺ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 28a. Date of injury (Month, Day, Year) I Director: After the Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be within 24 hours after d

To the Funeral Direct
completely filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifies (Check 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D55475 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Gebremedhin Yohannes

31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

1500 Forest Glen Rd.

32. Registrar's Signature

20910

Shring

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death PRINCE Physician/ 0:45AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore None If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8 Date of Birth Days (Month, Day, Year) Director 219-26-7336 15 M 2 - F 73 07/17/1938 MD If item 27 is marked other then "natural", or Items 23e or 28a-f shov or other traumatic event, the Modical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Columbia Howard 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5102 Running Brook Road 21044 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, or) Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐XYes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. 5+ Electrical Engineer BGE æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Lucille Miller Oscar Prince 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 5102 Running Brook Road Columbia, MD 21044 <u> Janet Prince - Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State Page 1 Importent: If ii eny Injury or o 1 🔀 Burial 2 🗀 Cremation 3 🗆 Removal from State 5/23/2012 4 ☐ Donation 5 ☐ Other (Specify) Marriottsville, MD Crest Lawn Mem. 21. Signature of Funeral Service License 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. uanto 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1 inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death ACUTE Physician/ MYOLARDIA disease or condition resulting in death) Medical Due to (or as a consequent of) Examiner I HROMBOSIS Sequentially list conditions, if any leading to humanical cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Exami attending physician and if for use as the buriel-transit The law requires that the death certificete be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Pregnant at time of death signed by the a P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, 1 ☐ Yes 2 ☐ No 3 Ă Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 1 ☐ Yes 2 ☐ No 2 1 No Division of Vital funeral director, 25. Was case referred to medical 8 26. Place of Death (Check only one) 10 1 Yes 2 🗹 No Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Could not be completely filled in by the 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tit 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15+ Marun ORLEANS STREET BALTIMORE MD 21287 PAVAN M.D. 1800 31. Date filed (Month egistrar's Signature State Exerci-Registrar

Physician Medica	1/	Registrar 1. Decedent's Name (First, Middle, Last) Zina Patricia Queen-Warren	2. Date of Month	Death Say Year 3. Time of Death
Examine		a. Facility Name (if not institution, give street and number) Doctors Community Hospital	4b. City, Town, or Location of Death Lanham	4c. County of Death Prince Georges
Funeral Director	8	Social Security Number 216-86-1720 Usual Residence of Decedent 6. Sex 1		Day, Yeal 1963 Country) ber 13, Cheverly, Mary
e Maryland r 28a-f sho notified at	irecto	Maryland Prince Georges Clinto [Oe. Street and Number]		10d. Inside City Limit 1X Yes 2 □ N 10g. Citizen of What Country?
s 23a or	Funeral I	9106 Fox Park Road	20735	United States
NU30 rs after death rral", or item Examiner m	2	1 Never Married 2 X Married 1 Ves 2 X No	Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🏿 No Specify:	14. Race - American Indian, Black, White, etc. Specify: Black
Z1Z15-0036 within 72 hours after ginen "natural", o her than "natural", o	Completed	(Specify only highest grade completed) (Give	odent's Usual Occupation I kind of work done during most of working OO NOT use retired) Specialist	16b. Kind of Business/Industry US Dept.of Treasury/ Bureau of Public Debt
Maryland 2 Should be filed w th and Mental Hyg 7 is marked othe traumatic event,	To Be	17. Father's Name (First, Middle, Last) Daniel Roger Griffin		cinda Queen
Mar 12 shou 1th and 27 is m r traum	i		ing Address (Street and Number or Rural Route Num Fox Park Road; Clinton, 1	
Baltimore, Imaryland 21215-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Seature of Pisposition 22b. Place of Disposition State Resurred Resurred 22c. Resurred		20c. Location - City or Town, State Clinton, Maryland rton Company Morticians
be exiciar	dical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		
ords, P.O. box 68/60, requires that the death certificate I been signed by the attending phys should be detached for use as the			☐ Ectopic pregnancy ☐ Other (specify)	23d. Date of delivery Month Day Year
ecords, P.O. e law requires that the has been signed by ge 2 should be deta	Completed by PI	Part II. Other significant conditions contributing to death but not resulting in the	24a. W	utopsy prior to completion of cause o death?
ivision of Vital or Attending Physician: after death. Director: After this certific i in by the funeral director.	Certificate: To Be	25. Was case referred to medical examiner? 1 Yes 2 No	26. Place of Death (Check only one) ent 3 DOA Other: 4 Nursing Home 5 R of 28c. Injury at work? M 1 Yes 2 No treet, factory, office 28f. Locatio	esidence 6 Other (Specify) De how injury occurred on (Street and Number or Rural Route Number, Town, State)
To the Hospital within 24 hours To the Funeral completely filled	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, death only one) 3 Certifying Nurse Practitioner: To the best of my knowledge.	estigation, in my opinion, death occurred at the time, da	ate and place, and due to the cause(s) and manner st

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Frank Leslie Rush, May 5:12P 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ivy Hall Nursing Home Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 90 229-07-4341 Director 1 X M 2 - F 9 1921 Washington, D.C. July Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State Director Baltimore Baltimore 1 🗌 Yes 2 🕱 No MD 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? Funeral 21219 2918 Delmar Avenue United States death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify If Yes, Give WWII White 3 Midowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Construction Brick Mason 10 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mildred Alice Dodson Frank Leslie Rush, Sr. and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 19209 Hempstone Ave., Poolesville, Maryland 20837 Frank L. Rush, III/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date ğ Ξ 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department Important: If any injury or 4 Donation 5 Other (Specify) 05/22/12 Goshen, Maryland Goshen Cemetery 21. Signal re il Funeral Servici Licensee 22. Name and Address of Facility Muriel H. Barber Funeral Home P.O. Box 5038, Laytonsville, Maryland 20882 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Failure to Thrive disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Dementia Sequentially list conditions, Examine if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of): Hypothyroidism and as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? ģ Debility 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ospital or Attending Physician: The law hours after death.

uneral Director: After this certificate has page 2 autopsy performed?

1 Yes 2 No 1 Yes 2 No Division of Vital filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 2 🗹 No Other: 1 🗌 Yes ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural 5 Pending injury work?
1 Yes 2 No Investigation Accident Suicide Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completely filled Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 5.16-2012 0073005 8813 Waltham Woods Rd, Suite 204, Baltimore MD-21284 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Sneeta

State

Registrar

31. Date filed (Month, Day, Year

MAY

arke

32. Registrar's Signature

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10 Mary 2012 11:45A M James C. Ragland Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Cheverly Prince George's Hospital Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year, Aug 26 1 Hours 215-37-5372 **Director** 1**X** M 2 □ F 1992 Maryland 19 Yrs. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified Maryland Anne Arundel Annapolis 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n ō Funeral 21401 USA 2825 Mockingbird Ct. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1X Never Married 2 Married 9 Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Year or Dates Black "natural", Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Health and Mental Hygiene. tem 27 is marked other than other traumatic event, the Me $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12th \end{array}$ College (1-4 or 5+) High School Student Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Myra Coleman Reginald B. Ragland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reginald B. Ragland (Father 2825 Mockingbird Ct. Annapolis, Md. 21401 item 2 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Cispasti on Name of Date o Department of Important: If it any injury or o once. 1 🗴 Burial 2 🗆 Cremation 3 🗀 Removal from State Memorial Gardens 5-19-12 Davidsonville, Md. 4 Donation 5 Other (Specify) Winname Recesse of &cilisons Mortuary, P.A. 21. Signature of Funeral Service Licenses 21401 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ MASSIVE TRAUMATIC BRAIN disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events burial-trar Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month 5 Other (specify) signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 1 Yes 2 No Division of Vital To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) May L, Voll Certificate: 28b. Time of injury **unk** 28d. Describe how injury occurred Driver 28c. Injury at 1 Natural
2 Accident
3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No May 5, 2012 HS 1 W 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after death.

To the Funeral Director: Al Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Road Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 366 250 a 1410 on who completed cause of death (Item 23a) (Type, Print) 30. Name and address of per-3001 MATIN HOSFITAL DEINE 31. Date filed (Month, Day, Year) 1 7 2012 State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 20/2 9:30 A Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Ginger Cove Health Center Annapolis Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** Hours Months Min. (Month, Day, Year) 475-20-9664 Director 1 M 2 X F 87 1/3/1925 Minnesota 28a-f shov 10d Inside City Limits 10a. State 10h Counts 10c. City, Town or Location notified at **Funeral Director** Annapolis 1 Yes 2 X No Marvland Anne Arundel 0 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? must be USA 21401 23a with 4202 River Crescent Drive items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status ıral", or iten Examiner ı Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🙀 No Specify: Specify: White "natural", 3★ Widowed 4 Divorced Completed nt of Health and Mental Hygiens.

If item 27 is marked other than "natur or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired Elementary/Secondary (0-12) College (1-4 or 5+) Paca House & Gardens Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Laura Johnsrud Martin T. Vollum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3109 Selwyn Farms Lane, Charlotte, NC 28209 Muriel Vollum - Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once. Baltimore Crematory 1 🗌 Burial 2 🔀 Cremation 3 🗋 Removal from State 5/18/2012 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, MD 21401 teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final Phylician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Dav Pregnant at time of death 5 Other (specify) be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an ate has page 2 s autopsy 1 Yes 2 director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ၉ 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) funeral Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 \(\sum \) Yes 2 \(\sum \) No 1 Natural 5 Pending injury Investigation Accident within 24 hours after death

To the Funeral Director: A Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

State Registrar

Medical

29a. Certifie

(Check

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use of death (Item 23a) (Type, Print)

N

Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2 Date of Death Decedent's Name (First, Middle, Last) Month Physician/ 8:40 P M Rockstroh 2012 Nancy T., May Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Center **Examiner** Anne Arundel Glen Burnie Marley Neck Health & Rehabilitation If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Hours Country 220-24-9940 83 Director 1 M 2 X F Maryland Nov. 16,1928 Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b Count 10c. City, Town or Location with the Maryland Director Severna Park 1 Yes 2 X No Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Funeral 21146 332 North Putney Way death v Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, et þ 1 Never Married 2 X Married White Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify If Yes, Give "natural", 3 🗌 Widowed 4 🗆 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be Edith Taylor Warren Taylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Husband permit. Page 1 and 2 she Department of Health an Important: If item 27 is any injury or other trau 332 North Putney Way Severna Park, MD 21146 Thomas J. Rockstroh, Sr., Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Baltimore, MD Metro Crematory, INC. 2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Barranco & Sons, 495 Ritchie Hwy, 21. Signature of Funeral Service Licensee Severna Park Funeral Home Severna Park, MD 21146 P.A. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Interval Between Onset and Death HYPERTENSION Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner DEMENTIA Sequentially list conditions, Examine (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury DIHYROIDISM burial-tra that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical death certificate be Box 68760 the use as t IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 \(\subseteq \text{ Yes} \) 2 \(\subsete \text{ No} \) 5 Other (specify) Month Day Year for Pregnant at time of death signed by the a Id be detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 No Unknown Records, Completed 24b. Were autopsy findings available 24a. Was an autopsy To the Hospital or Attending Physician: The law r within 24 hours after death. To the Funeral Director: After this certificate has b prior to completion of cause of death? performed?
1 ☐ Yes 2 🗷 No 2 🗌 No 1 Yes Division of Vital 26. Place of Death (Check only one) filled in by the funeral director, 25. Was case referred to medical Be examiner? Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) 2 🜠 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tyes ည 28c. Injury at work? 1
Yes 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: iniury Natural 5 Pending 2 \square No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 05/15 D58580 30. Name BÚL Name and address of person who completed cause of death (Item 23a) (Type, Print) LN , B21 . BOWIE , MD 20765

DHMH 17 Rev 06-2011

Registrar

State

Manu . 3233

MAY 16 2012

31. Date filed (Month, Day, Year)

SUPERIOR

32.

Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death May Physician/ 5:25AM 2012 Melissa Mae Rowland Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Meritus Medical Center Hagerstown, MD21742 Washington Social Security Number If Under 1 Year If Under Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours Min (Month, Day, Year) **Director** 219-68-0517 47 May 11, 1965 Waynesboro, PA 28a-f shov 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No PΑ Franklin Waynesboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 12041 Snyder Avenue United States Of America 17268 Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō 1 Never Married 2 X Married þ Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🗓 No Specify: "natural", Specify: 3 Widowed 4 Divorced Completed White the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 h and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Purchasing Manager Agricultural Equipment any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Paul Rumbaugh Linda Harty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Larry E. Rowland - Husband 12041 Snyder Avenue, Waynesboro, PA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 DRemoval from State May 23, 2012 4 Donation 5 Other (Specify) Cremation Society of PA Harrisburg, PA 17109 21. Signature of Funeral Service Libensee 22. Name and Address of Facility Auer Cremation 4100 Jonestown Services of Pennsylvania, Inc. Road, Harrisburg, PA 17109 23a Part 1/Enter the disease, or complications that caused shook, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Approximate Immediate Cause (Final Physician/ MOUN cancell disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner quentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed g physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: Ise 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No jo Month Day Year Pregnant at time of death Other (specify) Yes the a 9 Unknown a Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has page 2 s autopsy performed? Yes 2 N 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 Tyes မ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work?
1 \quad Yes Certificate: 28a. Date of Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After injury 5 Pending Natural 2 No Accident Investigation within 24 hours after death

To the Funeral Director: / 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year, M nd address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State Registrar	State of	Marylar			nt of H te of D		and N	Mental Hy	giene Reg. N	20	112	178	300
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To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		4 Homicide determin	building	, etc. (Specify	y)					City or To	vn, Stat	e)			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ PARL 1:48 PM 05 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death WASHINGRA MI-DICAL Gion BURNIE ANNE KALDMONE cribal ARUNOUZ 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days **Director** 213-28-5395 1**∑** M 2 □ F 80 Nov 10 1931 Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location Director Maryland Anne Arundel 1 ☐ Yes 2 🛣 No Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 229 Truckhouse Rd 21146 USA 11. Marital Status 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes. Give 1 Never Married 2X Married δ Maryland 21215-0036 1 ☐ Yes 2X No Specify. Year or Dates. 1950 – 53 Completed 3 Widowed 4 Divorced Black injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with h and Mental Hygien 7 is marked other th 9th 0 Longshoreman Loca1 333 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Smith Grace Johnson and 2 should the Health and Metern 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 2; any injury or other t. Geneva Smith(Wife) Truckhouse Rd. Severna Park, Md. 21146 Baltimore, 20a. Method of Disposition

1 A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Maryland Veteran 5-21-12 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Miname a Recese of Scill Sons Mortuary, P.A. Lavy 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of) sician and burial-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending physical for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 1 🗌 Yes မ 1 Hnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending work after death. 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the I Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 15, Physician/ James H. Selke 6:51 Α Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12516 Shetland Lane Bowie Prince George's 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Hours 220-34-3163 73 Director Aug. 7, 1938 Maryland Usual Residence of Decedent or 28a-f show s notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State the Maryland Director XX Yes 2 No MD Prince George's Bowie 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 20715 USA 12516 Shetland Lane should be filed within 72 hours after death v and Mental Hygiene. is marked other than "natural", or items aumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Restaurants / Equipment Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Willetta Hultz Clarence B. Selke other traumatic 19a. Informant's Name/Relationship (Type, Print)
Sandra D. Selke / Spouse 9b, Mailing Address (Street and Nymber or Rural Route Number, City or Town, State, Zip Code) 12516 Shetland Lane, Bowie, MD 20715 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 5/19/2012 Baltimore, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) Signature Funeral Service Licensee Beall Funeral Home 22. Name and Address of Facility 6512 NW Crain Hwy., Bowie, MD 20715 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest bause on each line. 232 Part 1. Enter the disease, or compli-shock, or heart failure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and initiated events.) Due to (or as a consequence of) burial-transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 the 38 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Day Year signed by the at Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by To the Hospital or Attending Physician: The law requires i within 24 hours after death.

To the Funeral Director: After this certificate has been sign Division of Vital Records, 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 X No 1 Yes filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of De 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Natural 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signatur title of certif

Registrar

DHMH 17 Rev 06-2011

State

30 Name and address

Day, Year) 1 7 2012

For

		State Registrar				Cer	tificate	of D	eath			Reg. No	20	12	17806	
Physiciar Medica	-	1. Decedent's Name (First, Middle Joseph Rud	olph Smit	_							2. Date of De May 14	, 20		Year	3. Time of Death 11:30 AM	
Examine	er	4a. Facility Name (if not institution 3112 Gracefiel					4b. City, To		Location Spr:				: County lontg		v	
Funeral Director		5. Social Security Number 213-30-0178	6. Sex 1 → M 2 □ F	7. Ag	e (In yrs. las	st birthday) Yrs.	If Under 1		If Under Hours		8. Date of Bir	th		g. Birth	place (State or Foreign	
ld now at	_	Usual Residence of Decedent 10a. State 10b. County				Town or Loc	ation							Mary	10d. Inside City Limits	
farylan Ba-f sh tified a	ecto	Maryland Montg	omery		Too. oity,	10111 01 200		i1v	er S	pring	3				1 Yes 2 XNo	
with the N 23a or 2 ust be no	Funeral Director	10e. Street and Number 3112 Gracefiel	d Rd Apt	320			10f. Zip C	ode	2	0904		10g. Citizen of What Co USA			ntry?	
fter death ", or items aminer mu	þ	11. Marital Status 1 Never Married 2 Mar	If You Gis	rces?	No		/as Deceder Yes, specify				cify Yes or No- Rican, etc.)	- 1	14. Race - American Indian, Black, White, etc. Specify: White			
atural	eted	3 ★ Widowed 4 □ Divorced	Year or D	ates.	51-55		ent's Usual (-						
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d 2 should alth and N 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Robert T. Basil - Nephew 19b. Mailing Address (Street and Number or Rural Route Number, 7056 Bembe Beach Rd, Annapol 20a. Method of Disposition 20a. Method of Disposition 20b. Place of Disposition (Name of Date 2											r Town, Si	tate, Zip (2140	Code) 3	
ge 1 an t of He If item or othe		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation	3 Removal from	State	ce	metery, crem	atory or other	er place	e)					-	own, State	
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Depri Impo any		Madent	Woher	*							nn M. T ster St				MD 21401	
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Medical Examiner		resulting in death)			a conseque											
	ner	Sequentially list conditions, if any, leading to immediate			drati a conseque	cEczer ence of):	na							+	Years	
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To Your		29b. Signature and little of certifier	Ly					icense 2403	number				te signed 15/2		Day, Year)	
10th		30. Name and address of person E. S. Macha	.do 311	se of d	eath (Item 2 Fracef	23a) (Type, Pi ield	Road,	Si1	ver	Spri	ng, MD	2090)4			
State Registra	e r	31. Date filed (Month, Day, Year)	2012 E	Registra	ar's Signatu	je span	Red									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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			Ss of person who	completed cause of de	eath (Item	23a) (Type, P	Drive Sui	te 120 a	Queenston	Wn.	MD.	216	58
State	-	31. Date filed (Month	h, Day, Year)	32. Registra	r's Signati	ire 4	1						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2012 Medical 4a. Facility Name (if not institution, give street and numb 4b. City, Town, or Logation of Death 4c. County of Death **Examiner** de de hA 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Number 6. Sex **Funeral** (Month, Day, Year) 86 577-30-6529 1 □ M 2 🗓 F Director 02/11/1926 Washington DC or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County Examiner must be notified at Director 1 Yes 2 X No MD Anne Arundel Shady Side 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 23a Funeral 20764 U.S.A. 5205 Lake Ave. "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, 11. Marital Status Black White, etc. þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: White Completed 3 X Widowed 4 Divorced 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than Elementary/Secondary (0-12) 10College (1-4 or 5+) Defense Contractor Solderer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Gugliami Rosina Telli Anthony 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1041 Diamond Dr. Churchton, MD 20733 Mike Snider (son) 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) permit. Page 1
Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 05/17/2012 | Galesville, MD Woodfield Cemetery Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home P.A. 905 Galesville Rd Galesville, MD 20765 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events the burial-transit that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform has page 2 death? 1 ☐ Yes 2 No Hospital or Attending Physician: The 44 hours after death. Funeral Director: After this certificate b 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, Medical Certificate: To Be 1 🗌 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🕱 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending iniury Natural Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral C

State

DHMH 17 Rev 06-2011

Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Date filed (Month, Day,

address of person who completed caus

Year)

16

death (Item 23a) (Type, Print)

ones egistrar's Signature

32

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

06054

6131 Shady

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Marilyn Ann Sperling 2012 1300 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1300 Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth Funeral (Month, Day, Year) Months 043-38-0076 1 □ M 2 🖔 F **Director** Yrs. 61 July 02, 1950 Connecticut Usual Residence of Decedent 10a. State 10c. City, Town or Location at Director notified 28a-f 1 Yes 2 X No Potomac Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? rms 23a or ö Funeral U.S.A. 20854 8812 Liberty Lane er than "natural", or items the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11 Marital Status Armed Forces?

1 Yes 2 X No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 X No Specify: If Yes, Give Year or Dates Specting, Marilyn Completed 3 Widowed 4 X Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) **5**+ Elementary/Secondary (0-12) Mental Health Psychologist and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be fill f Health and Mental item 27 is marked of မ Leo Sperling Frances Hurwitz Department of Health and Meni Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6403 Winnepeg Road, Bethesda, Maryland 20817 Rachel Schwartz - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 Cremation 3 Removal from State 05/18/2012 Olney. Maryland 5 Other (Speciff) Judean Mem. Gardens 4 Donation 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) for use as the burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Other (specify) Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page 2 Yes 2 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending injury 1 Natural Investigation ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 72607 16 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chen, MD Medical Center Dr. Robbill MV 20450 9901 31. Date filed (Month, Day, Year) 2. Registrar's Signature

State

Registrar

1 0 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Mark Victor Shannon 2012 2110 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours (Month, Day, Year) 212-66-8233 Director 1 🕱 M 2 🗆 F 57 10/13/1954 Washington, DC Usual Residence of Decedent 28a-f show 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 X No Maryland Silver Spring Montgomery 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? should be filed within remaining and Mental Hygiene. Funeral 20904 U.S.A. 13320 Bea Kay Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 X Never Married 2 Married þ ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Completed 3 Divorced 4 Divorced Black Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Fundraiser Non-Profit Organization Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Wilbert Clarence Shannon Odessa Elizabeth McKenzie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13320 Bea Kay Drive, Silver Spring, Maryland 20904 Odessa Shannon - Mother item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Ft. Lincoln Crematory: 05/23/2012 Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. Signature of Funeral Service Licenses 232 111800 New Hampshire Ave., Silver Spring, MD 20904 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Approximate Interval Between Onset and Death shock, or heart fa Immediate Cause (Final Physician/ Acute Myocardial Infarction Minutes disease or condition Medical resulting in death) Examiner Arteriosclerotic Cardiovascular Disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine e burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? jo Month Dav Pregnant at time of death Unknown ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗓 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has performed? Yes 2 X N death? 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital Other 1 ☐ Yes 2 🗶 No ျှ 1 ☐ Inpatient 2 🕱 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 24 hours after death. injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature a 29d. Date signed (Month. Dav. Year)

Registrar
DHMH 17 Rev 06-2011

State

James

(Month, Day, Year)

MAY 18 2012

Anthony Del Vecchio, M.D., 1500 Forest Glen Road, Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

May 16, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day 2012 Month 05 - 16 Physician/ AM 3:40 Daniel Leo Smith Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicamica Coastal Hospice at the Lake Salisbur If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours Min 9/6/1942 IL 329-34-1662 **Director** 1 🕽 M 2 🗆 F 69 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director notified 28a-f 1 🔀 Yes 2 🗆 No MD Ocean City Worcester 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ò items 23a or ner must be n Funeral 407 142nd St. 21842 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. or, þ 1 Never Married 2 XMarried X Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: "natural" Completed 3 Widowed 4 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Realtor Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 27 is marked Dorothy Elizabeth Jansen Leo Henry Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26515 Pemberton Dr., Salisbury, MD 21801 Adam Smith / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State ō 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Department or Important: If any injury or 4 Donation 5 Other (Specify) State Crem. 5/17/12 Millsboro, DE First 21. Signature Fundal Service Licenses 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. En 1 the disealle, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one causi or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MAYGNAN CARCINOMA UNI disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Days to for as a nonsequence off if any leading to immedicause. Enter Underlying Cause (Disease or injury the attending physician and the for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Pregnant at time of death 2 No Yes 9 Unknown q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a, Was an autopsy prior to completion of cause of death? this certificate has 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospita Other: HOSPICE 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence of Other (Specify) 27. Manner of D ath 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work?
1 Yes 2 No Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) Medical 29a. Certifiei Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signatur 29d. Date signed (Month, Day, Year)

BA 3+1 State Registrar

21802

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0.0

32. Registrar's Signature

1200

6 Harpar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Ma	aryland / Depa			ental Hygie	ne	17010
	_		Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of D		Reg. Date of Death	No. 2	3. Time of Death
	Physicia Medic		Thelma Mae Waddel	1 Spell			May 9,	2012 Year	0120 A. M
	Examin	er	4a. Facility Name (if not institution, give street and number) Washington Adventist Hosp	ital	4b. City, Town, or l	ocation of Death		4c. County of Death Montgomer	rv
N. C.	Funeral		5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday)			. Date of Birth		place (State or Foreign
	Director		241-36-9924 1 ☐ M 2 X F Usual Residence of Decedent	88 Yrs.	Months Days	O IVIIII.	. Date of Birth (Month, Day, Yea Ctober 2	8, North	Carolina
	land show dat	호	10a. State 10b. County	10c. City, Town or Loc	eation			1	0d. Inside City Limits
	Mary 28a-f	Jirec	District of Columbia	Washir					1 X Yes 2 No
	with the s 23a or ust be r	Funeral Director	10e. Street and Number 2505 - 13th Street, N.W.;	Apt. 311	10f. Zip Code 200 0)9		. Citizen of What Coun Inited Stat	•
9036	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent E Armed Forces? 1 □ Yes 2 ☒ 1 □ Yes 2 ☒ 1 □ Yes 2 ☒ 1 □ Yes 2 ☒ 1 □ Yes 2 ☒ 1 □ Yes 2 ☒ 1 □ Yes 2 ☒ 1 □ Yes 2 ☒ 1 □ Yes 2 ☒ 1 □ Yes 2 ☐ Yes 3 ☐ Yes 3 ☐ Yes 3 ☐ Yes 3 ☐ Yes 3 ☐ Yes 3 ☐ Yes 3 ☐ Yes 4	No.	Vas Decedent of His Yes, specify Cuban Yes 2 X No	panic Origin? (Specif , Mexican, Puerto Ric Spec <i>ify:</i>	y Yes or No- can, etc.)	14. Race - Americ Black, White, 6 Specify: B1a	etc.
21215-0036	ithin 72 hor ene. r than "nat the Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5	(Give k	ent's Usual Occupat iind of work done du O NOT use retired)	ring most of working	υ.	o. Kind of Business Inc . S. General Administrat	Services
and 2	2 should be filed within 7 h and Mental Hygiene. 7 is marked other than traumatic event, the M	To Be	17. Father's Name (First, Middle, Last)			18. Mother's Name (F			
Maryland	1 and 2 should be of Health and Men item 27 is marke other traumatic	[Louis Waddell 19a. Informant's Name/Relationship (Type, Print) (Daug	hter) 19h Mailin	a Address (Street an			y or Town State Zin C	Pode)
	and 2 sh Health ar te m 27 is		Patricia McNeil Irving					gton, D.C.	
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	1	sition (Name of patory or other place) ce Cremat (: -	,2012	c.Location - City or To	
Baltin	permit. Page Department Important: I any injury or once.		21. Synatur, Huneral Servi Livery ee	22	. Name and Address	of Facility R. N.	Horton	Company Mo	orticians,
			23a. Part 1. Enter the disease, or complications that caused	the death. Do not ente				wasnington	n,D.C.20011 Approximate
نبد	Physician/			ive Heart]	Failure				Interval Between Onset and Death
إمسيلا	Medical Examiner		resulting in death) Due to (or as a	a consequence of):					
	A	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a consequence of):					
	and transit	Examiner	Cause (Disease or illijury that initiated events c.	consequence of):				- 4	
0	ate be executed physician and the buriat-transit	edical E	resulting in death) Last Due to (or as a	consequence or,					
68760	tificate ng phy as the	Medi	IF FEMALE:						
Box 6	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transi	Physician/M	23c. If yes, outcome	2 🗌 Fetal death 3 📃	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
P.O.	that the ned by e detac	by Ph	Part II. Other significant conditions contributing to death be	ut not resulting in the u	nderlying cause give	n in Part I.	23e. Did tobacc	co use contribute to th	e cause of death?
ds,	quires en sign						1 🗌 Yes	2 No 3 Prob	pably 4X Unknown
Division of Vital Records,	sician: The law re certificate has be irector, page 2 sh	Completed					24a. Was an autopsy performed 1 \(\sum \) Yes 2 \(\begin{array}{cccccccccccccccccccccccccccccccccccc	prior to cor death?	osy findings available mpletion of cause of 2 No
ital	iysician: iis certific director,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	V	1	e of Death (Check or			
of V	g Physer this neral di	te: To	27. Manner of Death 28a, Date of injur		28c. Injury a	4 ☐ Nursing Home	5 Residence I. Describe how in	e 6 Other (Specify) njury occurred	
ion	tendin leath. tor: Aff the fur	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be			es 2 🗆 No			
Divis	al or Attending Physis after death. Il Director: After this din by the funeral d		4 Homicide determined 28e. Place of Inju building, etc	ry - At home, farm, stre . (Specify)	et, factory, office	28f	Location (Street City or Town, St	and Number or Rural ate)	Route Number,
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completed filled in by the funeral or the funeral o	Medical	29a. Certifier (Check only one) 1 X Certifying Physician: To the best of examiner: On the basis of example of the control of the last of the last of example of the last of example of the last of example of the last of the last of example of the last of the	amination and/or investi	gation, in my opinion,	, death occurred at the	e time, date and pla	ace, and due to the cau	ıse(s) and manner stated.
_	5 5 8 € 6 8	-	005 0:		29c. License r	number	29d.	Date signed (Month, E	Day, Year)
	3		296. Signature and title of certifier	- th //h 00 \ =	D 403			ay 16, 2	012
	EL.		30. Name and address of person who completed cause of de TERM JODRIE, MD, FACEP	eatn (Item 23a) (Type, Pi		arroll Ave Park, Mar		20912	
	Stat Registra		31. Date filed (Month, Day, Year) RAY 21 2012 32. Registra	r's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5:50 A M Henry Summons Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Doctor's Community Hospital Prince George Lanham If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 02/28/1920 **Director** 92 230-16-0297 1**XX**M 2 □ F Yrs. Virginia Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 No Maryland Prince George Laure1 10f. Zip Code o 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a or 7903 Orion Circle Apt. 224A 20724 U.S.A. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 \square Never Married 2 $\overline{\mathbf{X}}$ Married 2 If Yes, Give Year or Dates. 1 ☐ Yes 2 XNo Specify: Specify: Black 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Carpenter Private Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill tment of Health and Mental tant: If item 27 is marked o မ Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S 7903 Orion Circle Apt.224A Laurel, MD 20724 Johnnie Mae Summons 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date Department of H Important: If ite any injury or ot once, 1 Burial XX Cremation 3 Removal from State Fort Lincoln Crematory 5/18/2012 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licens 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722 23a. land). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death 0 Physician/ disease or condition Medical resulting in death) **Examiner** 100 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner the burial-transi Cause (Disease or injury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day 4 Pregnant at time of death 9 Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 1 Yes 2 No Hospital or Attending Physician: 7 Hours after death. Within 24 hours after dearn.

To the Funeral Director, After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 Tes 2 N မ 1 Department 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year, Natural 5 Pendina Accident 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number. determined building, etc. (Specify) Medical 29a. Certifier rifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Contifying Nurse Practitioners To the best of my knowledge "death onested at the time; dath and place, and due to the councils) and manner as state 29b. Signature and 05116 DC7 710 0. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8118 Good Luck Rd., Lanham, MD. 20106 Abiodun MIDO State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ Month JORDAN В. STAPLES 7:05 A M 2012 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5077 Temple Hill Road Temple Hill Prince George's 8. Date of Birth (Month, Day, Year Nov 29, 1 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 | F Days Hours Yrs Director 1945 Tennessee 410-70-7510 66 Usual Residence of Decedent ural", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🙀 Yes 2 🗌 No Maryland Prince George's Temple Hill 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 5077 Temple Hill Road 20748 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces Black, White, etc 1 Never Married 2 Married ģ Yes 2 XNo hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: African If Yes, Give "natural", 3 Widowed 4 Divorced Completed Year or Dates American the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) giene. life DO NOT use retired $\begin{array}{c} \text{Elementary/Seconday (0-12)} \\ 12th \end{array}$ College (1-4 or 5+) Private 2 should be filed with the and Mental Hygien 7 is marked other th Truck Driver permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Ella Long Verna Staples 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Staples - Wife 5077 Temple Hill Road Temple Hill, Maryland, 20748 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May 25. cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 2012 4 Donation 5 Other (Specify) Suitland, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. T. Stervar 4001 Benning Road NE Washington, DC 20019 M00560 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Metastatic Bladder Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate
Cause (Disease or linjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 ast IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? for Dav Pregnant at time of death the 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Hunknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has page this certificate 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Tes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatui icense number 50 May 21, 2012 D15185 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20010 Suite 2200N Washington, DC 106 Irving Street NW M.D., MBA John E. McKnight,

DHMH 17 Rev 7/2009

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	State of Maryland / Dep State Registrar State of Maryland / Dep	artment of He		ental Hygier Reg. I	0010	17815
	Physicia	an	1. Decedent's Name (First, Middle, Last) Margaret Diehlmann Snyder				Day Year 16 2012	3. Time of Death 11:28 AM
	/Medic Examin	er	4a. Facility Name (If not institution, give street and number) 11014 Stewart Neck, Rd.	4b. City, Town, or L	s Anne	4	4c. County of Death Somerset	
	Funeral Director	0 33	5. Social Security Number 220-07-3631 6. Sex 1 M 2 F 7. Age (In yrs. last birthday 96 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Yea March 9,	ar) Coui	place (State or Foreign htry) Maryland
	aryland show ed at	or .	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L		 -	<u></u>		10d. Inside City Limits 1 ☐ Yes 2 No
	th the M or 28a-f e notifie	Funeral Director	Md. Somerset Prince	ss Anne 10f. Zip Code		10g.	Citizen of What Cou	ntry?
	s 23a c	aral [11014 Stewart Neck Road 11 Marital Status 12, Was Decedent Ever in U.S. 13		1853		Jnited Sta	
036	urs after de al", or item Examiner r	P	11. Marital Status 1 □ Never Married 2 □ Married 3 ■ Wildowed 4 □ Divorced 12. Was Decedent Ever in 0.5. 13. Married Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	Was Decedent of His If Yes, specify Cuban	Specify:	lican, etc.)	Black, White,	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show minportant: If item 27 is marked other than "natural", or items 23a or 28a-f show minportant; If item 27 is marked other than "helical Examiner must be notified at once.	Completed	(Specify only highest grade completed) (Giv Elementary/Şecondary (0-12) College (1-4or 5+)	edent's Usual Occupat e kind of work done du DO NOT use retired) avel Agent	uring most of workin	g 16b	. Kind of Business/Ir Sa]	
5 0	ifiled v I Hygie other t ent, th	Be Co	17. Father's Name (<i>First, Middle, Last</i>)			(First, Middle, Maid		.es
ylan	should be and Mental s marked o umatic eve	To B	Conrad H. Diehlmann			ehead Die		
Maryland	d 2 sho Ith and 17 is ma traum		Total Maria Control of	ling Address (Street at 4 Stewart		•		,
	es 1 and of Health fitem 27 rother tr		Mr. Louis Volandt Son 1101 20a. Method of Disposition 1 □ Burial 2 ■ Cremation 3 □ Removal from State	oosition (Name of ematory or other place	e) : Da	ate 20c	. Location - City or T	own, State
Baltimore,	permit. Pages 1 a Department of Hes Important: If item any Injury or othe once.		4 □ Donation 5 □ Other (Specify) Sallsbu	ry Cremato		/2012 Sal	Lisbury, N	ſd.
Ba	Deparation of the concession o	1	21/- 200295	11673 Some	Н		neral Home	
	Physician · /Medical		23a. Part / Enter the disease, or complications that caused the death. Do not especially considered the death of the shock, or heart failure. List only one cause on each line. Impedite Cause (Final disease or condition resulting in death) Due to (or as a or sequence of):	nter the mode of dying	g, such as cardiac	r respiratory arrest,	s anne,	Approximate Interval Between Opset and Death
	Examiner		Sequentially list conditions, b.					years
	nsit	Examiner	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury	/				UPANS
,092	ate be executed hysician and he burial-transit	cal Exa	that initiated events resulting in death) Last C	14.00+18.0				7
89	ertificat ing phy e as th	Medi	IF FEMALE:					
.O. Box	w requires that the death certifica been signed by the attending phi should be detached for use as th	Physician/Med	23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of delive Month	rery Day Year
<u>α</u>	uires that I signed by d be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause give	en in Part I.		co use contribute to 2 No 3 Pro	the cause of death?
Vital Records,	E 25	Completed				24a. Was an autopsy performed	prior to c	opsy findings available ompletion of cause of
tal		Be Co	25. Was case referred to medical		26. Place of Death	1 Yes 2	No 1 ☐ Yes	2 No
i V	Physician: this certific	To B	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati		4 LI Nursing Hor		e 6 □Other (Spec	ify)
ouo	ding P h. After t funera		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Nacylent investigation	Work	/at t? Yes 2 □ No	28d. Describe how i	njury occurred	
Division or	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)			28f. Location (Stree City or Town, S	t and Number or Ru tate)	ral Route Number,
	ne Hospital n 24 hours a ne Funeral I	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manyer stated.	ath occurred at the tim investigation, in my or	ne, date and place, a pinion, death occurr	and due to the caus ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the complet	M	Sub. Signature and title of certifier	29c. License		29d.	Date signed (Month	, Day, Year)
	P		30. Name and address of person who completed cause of death (Item 23a) (Typ Breth Hofmann 30434 Mt Verno	n Rd Pri	ncess	Inne M	12185	3
	Sta Regist	ate rar	Brett Hofmann 30434 Mt Verno 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 22 2012	park				
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Clyde Archie Thomas 2012 May 16, 12:45 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Edenton Retirement Community Frederick Frederick Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Day: 218-09-7900 **Director** 1 X M 2 □ F 92 November 18, 1919 Maryland Usual Residence of Deced d Hygiene. I other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Adamstown 1 Yes 2 X No 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 5561 Mountville Road 21710 United States of America 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 X Yes 2 No World
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No 3 ₭ Widowed 4 □ Divorced Specify: White Completed War II Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Warehouse Manager Canning permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lee Cephas Thomas Kate Crum Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marybelle Posey / Daughter 5559 Mountville Road, Adamstown, Maryland 21710 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Mount Olivet Cemetery 4 Donation 5 Other (Specify) May 21, 2012 Frederick, Maryland Signature of Fune al Service Line 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, Maryland 21701 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician romyarat disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any leading to immediate cause. Enter Underlying Due to for as a nonsequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed 1 Yes 2 1 4 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 € To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Sisted 1 🗆 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S Ulmson CIVI

State

Registrar

31. Date filed (Month, Day, Year)

MAY

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2012 Physician/ Month Audrey A. Treadway May 5:20A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Joseph's Ministries, Frederick Inc. Emmitsburg Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min (Month, Day, Year) Country) 213-40-9579 **Director** 1 □ M 2 🛛 F 100 July 8 1911 Minnesota Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d, Inside City Limits Examiner must be notified at Director 1 Yes 2 X No MD Frederick Rocky Ridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō items 23a Funeral 21778 United States 14409 Old Frederick Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc ò 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White "natural", Completed 3 ₺ Widowed 4 □ Divorced the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Ments. Important: If item 27 is marked any injury or other trainment. P Amaliea Turvander John Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21778 14409 Old Frederick Road, Rocky Ridge, MD John Treadway / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 05/18/12 Brinklow, Maryland Woodside Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Muriel H. Barber Funeral Home 21. Signature of Funeral Service Acepsee P.O. Box 5038, Laytonsville, Maryland 20882 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Endstage Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam Cause (Disease or injury that initiated events -trar Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month 5 Other (specify) Pregnant at time of death signed by the a d be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Records, 1 Yes Completed plnods 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 page 2 s has 25. Was case referred to medical 26. Place of Death (Check only one) of Vital Be Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 2 No 1 Yes ER/Outpatient 3 DOA ည 1 Inpatient 2 in 24 hours after uca...
he Funeral Director: After th 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending 1 Yes Division 2 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 3 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, and address of person who completed cause of death (Item 23a) (Type, Print) wes 10 OR CL 0 u

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5/17/2012 Day 4:49 A Helen Marie Truitt Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7803 Libertytown Rd Berlin If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth g. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Hours Min Country 1 □ M 2 F **Director** 213 24 0041 87 6/24/1924 MD Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ral", or items 23a o Examiner must be Funeral 7803 Libertytown Rd. USA 21811 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married Completed by 215-0036 1 ☐ Yes X ☐ No Specify: Specify: white If Yes, Give "natural", 3 Widowed 4 ☐ Divorced Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Page 1 and 2 should be filed within 72 Elementary/Secondary (0-12) College (1-4 or 5+) Poultry Grower/ Paper delivery 2 Be 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) 2 Martin Hudson Blanche Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Evelyn Hartsell (daughter) 7803 Libertytown Rd. Berlin, MD 21811 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Riverside Cemetery 4 Donation 5 Donation 5 Donation 5/21/2012 Berlin, MD 21811 al Service Licen 22. Name and Address of Facility 2. Name and Address of Facility The Burbage 108 William St. Berlin, MD 23a, Part 1. Enter the disease, or complications tha caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause of Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of if any, leading to immedi cause. Enter Underlying Exam Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last the burial-tran and Due to (or as a consequence of): nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past \$2 months?
1 ☐ Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 1 Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 \square Pending 2 No 24 hours after death.

Funeral Director: A 1 Yes Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) re and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Day, Year)

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			for State Registrar	State of N	nai yiai iu / i	Certific			allu ivi	ена пу	Reg. N	201	2	178	3 9
П	Physicia	in/	Decedent's Name (First, Middle, L.	ŕ	agua II kaul	0 C F +				2. Date of De Month		ay 2 ^{Yea}		3. Time of De	
Ž vy	Medic Examir		4a. Facility Name (if not institution, gi	Cobert Grav			ity, Town, o	r Location o	of Death	мау		ay Yea 2 201 c. County of De		1:10	u IVI
Sugar			Suburban I			4 (-)		ethese				Мо	ntge	omery	
	Funeral Director			Sex 7. A 1 X M 2 □ F	ge (In yrs. last birt	Yrs.	hs Days	Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 12/28	ay, Year)		Country)	ce (State or Fi	oreign
	Maryland 28a-f sho otified at	Director		gomery	10c. City, Towr	or Location	Si	lver S	Sprin	ıg			10d	Inside City L	
	/ith the 23a or st be n	ralD	10e. Street and Number	nard Drive)	10f.	Zip Code	2091	0		10g. C	itizen of What	S.A		
336	is filed within 72 hours after death with the Manyland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent		If Yes, s	cedent of H pecify Cuba s 2 X No	lispanic Oriç an, Mexican	gin? (Spec	cify Yes or No- Rican, etc.)		14. Race - Ar Black, Wh Specify:	nerican ite, etc.		
2-0(2 hours "natur edical B	Completed	15. Decedent's (Specify only highest o	Education	16a.	Decedent's L (Give kind of	Isual Occup	ation	t of workin	na	16b. I	Kind of Busines	s/Indus	try	
Baltimore, Maryland 21215-0036	within 7; giene. er than	Com	Elementary/Secondary (0-12)	College (1-4 or	5+)	life. DO NOT	use retired)			9	l u	.S. Gov	i e tin	ment.	
nd	be filed w ental Hyg ked othe ic event,	To Be	17. Father's Name (First, Middle, Last	,						(First, Middle,	Maiden	Surname)			
ıryla		۲	Joh 19a. Informant's Name/Relationship	.n Goode Ur (Type Print)		Malling Add	unna /Ctroot	and Mumba	ou Dougl			er Heiv r Town, State,		la)	
, Na	ge 1 and 2 should by the of Health and Mer I fitem 27 is marke or other traumatic		Rosa Natalie Min		7.						, ,			,	0
ore	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other		20a. Method of Disposition 1 X Burial 2 Cremation 3		e cemeter	f Disposition (i	or other plac			ate		ocation - City			
altin	permit. Pag Departmen Important: any injury once.		4 ☐ Donation 5 ☐ Other (Specal 21. Signature of Funeral Service Lice	*	Judean							rey, Ma Funero			NO.
Ä	Depar Impo any ir		> Our	Dame	01	11800	New	Hamps	hire	Ave.,	Silv	er Spri	ng,	MD 20	904
	thirdclan/		23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	one cause on each lir	ne.	ot enter the m	ode of dyin	g, such as o	cardiac or	respiratory ar	rest,		In	oproximate terval Betweenset and Dea	
	Medical Examiner		disease or condition resulting in death)		a consequence o	•									
	Examiner	er	Sequentially list conditions,	D. =	Bowel C		tion						-		
	executed an and	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C											
_	Ψ G =	_	resulting in death) Last	Due to (or as	a consequence o	of):									
3760	ficate k g physias the	Medic		d											
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. Within 24 hours after death. To the Luneral Director. After this certificate has been signed by the attending physician parapletely filled in by the funeral director, page 2 should be detached for use as the bure	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 ☐ Fetal death at time of death	3 Ectop 5 Other		су				23d. Date of o	delivery Da	y Year	ŕ
s, P.O.	requires that the des been signed by the s should be detached	by	Part II. Other significant conditions	contributin g to death	but not resulting i	n the underlyin	ng cause giv	ven in Part I.	l.			use contribute			
ord	w requisible been 2 should	Completed								24a. Was				findings avai	
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Vital	Physician: The law this certificate has al director, page 2	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	tient 2 🗆 ER/Ou	tnatient 3	Othe	ace of Deatler:			danca l	6 ☐ Other (Spe	aciful		
of	ding Phy h. After thi funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of inj (Month, Da	ury 28b. T	ime of njury	28c. Injun work	y at :?	2	8d. Describe			спу		
Division of Vital Records,	Attendi r death ector: A by the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not 4 Homicide determined	be 28e. Place of In	jury - At home, far	m, street, fact		Yes 2	_	8f. Location (Street ar	nd Number or F	ural Ro	ute Number,	
<u>.</u> <u> </u>	Hospital or Attenc 24 hours after death Funeral Director: etely filled in by the			building, e	tc. (Specify)					City or Tov					
	e Hosp 24 hol e Fune pletely f	fedical	(Check 2 Medical Exar	ysician: To the best o niner: On the basis of Irse Practitioner: To the	examination and/or	r investigation,	in my opinio	on, death oc	curred at t	he time, date a	and place	e, and due to the	e cause(r stated.
	within 2	5	29b. Signature and title of certifier		6			number 66 L-0				ite signed (Mor			
			30. Name and address of person who Babak Salehi Pi				naota	un Da	ad 1						
	Stat		31. Date filed (Month, Day, Year)	2. Regist	rar's Signature	harles	ryero	VOIL NO	uu, l	secresi	ing 1	mucgeun	u L	0014	
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DHMH 17 Rev 06-2011

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

Physician/ Medical Examiner As Facility Name (if not institution, give street and number) 123 Collington Court 123 Collington Court 123 Collington Court 124 Separate of Deadth Annold A	e of Death
123 Collington Court Arnold Arnol	
Total Control Total Country Total Countr	
10a. State 10b. County 10c. City, Town or Location 10c. City, Town or Location 10c. City 10c. Inside 10c. Inside 10c. City	
23a. Part 1. Exter the displace, obcomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	le City Limits Yes 2 X No
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23a. Part 1. Expert the glasse, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	L Hom
	2 S
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery 1 Very 2 Very 3 Very 4 Pregnant at time of death 5 Other (specify) Month Day 9 Unknown 9 Unknown Post Workship time to death but not residue to the control of the contro	Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	
1 Yes 2 No 3 Probably 4	
25. Was case referred to medical examiner?	
3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route No. 1) City or Town, State	ımber,
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of injury (Month, Day, Year) 28b. Time of injury M 1 Yes 2 No 28c. Injury at work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how inj	
Jan 2 breen w 17 D 16964 5-14-1	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Chacanas 1509 Ritches Huy Arnold WB 210 State 31. Date filed (Month, Day, Year) 32. Rigistrar's Signature	

12-03690 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Andrew Martin Vinson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Reglatrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day May 14, 2012 Medical Examiner Andrew Martin Vinson 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Gambrils Gambrills 2251 Dairy Farm Road Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Davs Hours Director 217-50-9737 1 X M 2 F 65 9/28/1946 Usual Residence of Decedent 10c. City, Town or Location 10a. State iftimore, MD 21215-0036

attit. Pages I and 2 should be filed within 72 hours after death with the Maryland attitent of Health and Montal Hygiene.

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show ry or other traumatic event, the Medical Examiner must be notified at once. Anne Arundel Gambrills Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21054 USA 2251 Dairy Farm RD Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1XX Never Married 2 Married 2 4 Divorced or Dates: 1967-1971 3 Widowed 1 Yes 2 X No specify: Specify. Ď 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Painter House Painter 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Wilbur Vinson Sara Martin æ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ۵ Harriett Bronson 2251 Dairy Farm Rd. Gambrills, MD 21054 Friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 XX Cremation 3 Removal from State Department or Important:] 5/17/2012 | Glen Burnie, MD Atlantic Crematory Donation 5 Other Specify 22 Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee Ridgely Ave. Annapolis, MD 21401 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line. /Medical a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit Physician/Medical x AMENDED #4b, per me, g928 6-25-12 sm UNPENDED Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify, į 1 Yes 2 No 9 Unknown 9 Unknown ned by the a detached fo Part II. Other algnificant conditiona contributing to death but not resulting in the underlying cause given in Part I. certificate has been signed by ector, page 2 should be detach <u>۾</u> Completed 24a, Was an autopsy performed? Yes 2 ✔ No funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 1 🗸 Natural 1 Yes 2 No Pendina the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide Homicide

23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✔ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi Other 1 Nursing Home 5 Residence 6 🗸 Other: Scene 28d. Describe how injury occurred filled in by 28f, Location (Street and Number or Rural Route Number, City 29a. Certifier 1 [completely Certifying Phyalclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E May 15, 2012 4x1 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Ana Rubio MD 32 Registrar's Signature 31. Date filed (Month, Day, Year State Registra 6 ORIGINAL **OGME**

1215 hrs

AL

10d. Inside City Limits

1 Yes 2 X No

Approximate Interval

Between Onset and

Death

Country)

White

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Ruth Worrell 0340 May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgomery Silver Spring 8. Date of Birth (Month, Day, Year) **Funeral** Social Security Number Year If Under 24 Hrs. 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) Months Days Hours 578-32-1159 Director 1 M 2 X F 87 Yrs 01/09/1925 Washington, DC Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits Maryland Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 2101 Fairland Road 20904 U.S.A. or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", If Yes Give 1 Yes 2 X No Specify. Completed 3 X Widowed 4 Divorced Specify. Black hould be filed within 72 hours and Mental Hygiene.

s marked other than "natural umatic event, the Medical E Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Secretarial Assistant Federal Government Be 17. Father's Name (First, Middle, Last) snould be filk th and Mental h 18. Mother's Name (First, Middle, Maiden Surname) ပ Lester Johnson Ruth Peterson permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Bethesda Metro Center #460. Bethesda. MD 20814 Sigrid Haines - Attorney 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🗆 Burial 2 🖾 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 05/23/2012 Brentwood, Maryland HOIOZY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute Funeral & Cremation Center ald 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Aspiration Pneumonia Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) buria attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death ed by the a 1 Yes 2 9 Unknown 2 X No g Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b 23e. Did tobacco use contribute to the cause of death? Completed by Advanced Dementia Records, 1 Yes 2 No 3 Probably 4 🗓 Unknown been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Severe Osteoarthritis page 2 autopsy performe death? Hospital or Attending Physician: The this certificate Yes 2 K No 1 Yes 2 No Division of Vital director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner?
1 Yes 2 X No Hospital Other: ၉ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 X Natural Accident 1 Yes 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d. Date signed (Month, Day, Year) D45471 May 14, 2012

State Registrar 30. Name and addless of persor

Date filed (Month.

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2012

M.D.

DHMH 17 Rev 06-2011

1500 Forest Glen Road, Silver Spring, Maryland 20910

pleted cause of death (Item 23a) (Type, Print)

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NSTON 2012 Medical a Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner 4c. County of Death If Under **Funeral** ge (In yrs. last birthday) 24 Hrs Min. 8. Date of Birth 9. Birthplace (State or Foreign 272-70-1676 Days Months Hours (Month, Day, Year) Director 1 ₹ M 2 □ F 53 Yrs MAY 2,1959 DAYTON, OH 28a-f show within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "natural", or iteme 23a or 28a-f sho reumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits PG UPPER MARLBORO 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 706 COFFREN PLACE Funeral 20774 US Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 ☐ Yes 2 X No 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced If Yes, Give Specify: BLACK Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) TRUCK DRIVER PRIVATE t. Page 1 and 2 should be filed with them of Health and Mental Hygler tant: If Item 27 is marked other 1 jury or other treumatic event, in 12TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) be ပ္ SAMUEL N. WINSTON SR. BOBBIE REECE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARK S. WINSTON JR. 706 COFFREN PLACE, UPPER MARLBORO, MD 20774 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remoyal from State cemetery, crematory or other place, WEST MEMORY GARDENS 4 ☐ Donation 5 ☐ Other (Specify) MAY 25, 2012MORAINE, OH 21. Signatury of Funeral Service Licer 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or Injury Due to (or as a consequence of): Exami attending physician and I for use as the buriai-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day Year been signed by the s should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Records, Completed 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 perform 1 ☐ Yes 2 X No 1 Yes 2 No Division of Vital B 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 D No Other: 욛 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) . Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fur Investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Pragititioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2/28 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Otis Williams Physician/ 2012 Month Day 11:15a M Medical 4a. Facility Name (if not institution, give street and number)
4007 Beachcraft Court Examiner 4b. City, Town, or Location of Death 4c. County of Death Temple Hills Prince Georges Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1**X** M 2 □ F 78 Months Days Hours Mir (Month, Day, Year) 9 / 3 / 19 577-50-5501 **Director** Missispi Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 10b. County
Prince Georges 10c. City, Town or Location Temple Hills 10d. Inside City Limits MD 1 X Yes 2 □ No 10e. Street and Number 4007 Beachcraft Court 10f. Zip Code 10g. Citizen of What Country? Funeral 20748 USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify:Black If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired)
Truck Driver Smith & Mayflower Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Hazel Williams Roxie Dent 19a. Informant's Name/Relationship (Type, Print)
Ronald Shamley/Cousin 19b Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) 20748 4007 Beachcraft Court Temple Hills MD. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Riverdale Park 5/23/12 Riverdale MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dunn & Sons-5635 Eads St. NE MO1388 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each tipe. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy be detached for in the past 12 months? Pregnant at time of death 5 Other (specify) Month Year Day Yes 2 No g Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed' 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: ' completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 🗹 No Other: ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred (Month, Day, Year) 1 Matural 5 Pending Accident 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) VMULO Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Date filed (Month, Day, Year)

400

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 23:00 M May 19 Lawrence M. Williams Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Fort Washington Fort Washington Medical Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth **Funeral** 1 🗷 M 2 🗆 F ne 28 1934 DC June 77 Director 578**-**42**-**5496 Usual Residence of Deceden ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 72 hours after death with the Maryland Directo 1 X Yes 2 No Fort Washington Prince George's Maryland 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Funeral United States 20744 1701 Dauphin Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 X No If Yes. Give "natural" 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Private Procurement Specialist 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Madeline Wood William Richard Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8700 Oxon Hill Road Fort Washington, Md. 20744 Lauren W. Bennett / Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of May 29, permit. Page 1 a
Department of IImportant: If ite
any injury or ot cemetery, crematory or other place)
Maryland
eterans Cemetery 1 X Burial 2 Cremation 3 Removal from State 2012 Cheltenham, Maryland 4 Donation 5 Other (Specify) Veterans 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, John T. Stewart 20019 Washington, DC M00560 4001 Benning Road NE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Mysearder disease or condition resulting in death) Medical Due to or as a consequence of) Examiner monor Sequentially list conditions, frank, leading to immediate cause. Enter Underlying Exami The law requires that the death certificate be executed Cause (Disease or iiniury attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of page 2 s has autopsy performe death? 1 Yes 2 No certificate Yes 🕰 or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Hospital: 20 No 1 Tes ဂ္ 1 Inpatient 2 FR/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) iniury Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical to Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar 31. Date filed (Month, Day, Year, 32. Registrar's Signatu MAY 2 3 201

MO

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

29b. Signature and title of certifie

ROSIN

11711 LIVINGSTON RD

D0065385

FORT WASHINGTON

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lee Watson Joseph NAY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctor's Hospital Lanham Prince George's . Social Security Number if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Min. (Month, Day, Year, Months Davs Hours **Director** 579-42-0906 1 XM 2 □ F 78 Yrs. Jan 31, 1934 Washington, DC Usual Residence of Decedent show 10a. State 10c. City, Town or Location notified at 10d Inside City Limits Director Maryland Prince George's Upper Marlboro 28a-f 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? must be 23a Funeral 20772 9600 Tiberias Drive United States items (12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ir than "natural", or iter the Medical Examiner Armed Forces?

1 Yes 2 XNo
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify. 3 ♥ Widowed 4 □ Divorced Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working 1 and 2 should be filed within 72 if Health and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 years Tailor Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Lee Watson, II Mary E. Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darold E. Watson - Son 9600 Tiberias Drive Upper Marlboro, MD 20772 Page 1 and 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of F Important: If ite any injury or oth 24 2012 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Lee's Crematory Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) Sig Viu e of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. M00560 4001 Benning Road, NE Washington, DC 20019 293. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph, sician MOXIC disease or condition resulting in death) brain Medical Examiner myo cardial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or) Cause (Disease or injury and -tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buris Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year g Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? Yes 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 9 No မ ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this of funeral directions of the following the foll 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural within 24 hours after www...

To the Funeral Director: After was a second of the funeral end of the funeral 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. an/ Alemas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

2012

8118 GOOD LUCK

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Date of Death Physician/ Jean Zimmerman May 2012 Medical 10:50 A M 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Glade Valley Center Walkersville Frederick Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Hours 213-82-5562 Director 1 □ M 2**X**□ F 96 08/05/1915 Maryland Usual Residence of Decedent 28a-f show 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location Director 10d. Inside City Limits must be notified MD Frederick Walkersville 1 X Yes 2 □ No or, 10e. Street and Number 10f. Zip Code Citizen of What Country? Funeral 23a 56 W. Frederick St. 21793 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force 10 þ Black, White, etc. 1 Never Married 2 Married 2 X No 1 ☐ Yes 2 X No Specify: 3X Widowed 4 □ Divorced If Yes, Give "natural" Completed Specify: White Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ည of Health and Menti fitem 27 is marked rother traumatic e Wilbur Tuck Bessie Lilv and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul A. Zimmerman, Jr./ son P.O. Box 223, New Market, MD 21774 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State o = o 1 Durial 2 X Cremation 3 Removal from State cemetery, crematory or other place Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 5/3/2012 Smithsburg, Maryland 21. Signature of Funeral Service Licenseer 22. Name and Address of Facility Keeney & Basford Funeral Home MO1222 106 E. Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician! Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) attending physician by Physician/Medical IF FEMALE: ned by the a e detached f pe (Completed , page 2 s certificate has funeral director, Be 힏 this Certificate:

Records,

Baltimore, Maryland 21215-0036

the Hospital or Attending Physician: Division of Vital within 24 hours after death.

To the Funeral Director: After

23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live Birth 2 4 Pregnant at tir	Fetal death 3 🗌 Ector	oic pregnancy r (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions		not resulting in the underly	ng cause given in Part I.		use contribute to the cause of death?
ahral fi	ulation			24a. Was an autopsy performed?	
25. Was case referred to medical examiner?	·		26. Place of Death (Che	ck only one)	
1 Yes 2 No	lospital: 1	2 ER/Outpatient 3 E	DOA Other: 4 Nursing I	Home 5 Residence	6 Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigati 3 Suicide 6 Could not		28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	
4 Homicide determine	28e. Place of Injury building, etc. (S	At home, farm, street, fac pecify)	tory, office	28f. Location (Street a. City or Town, State	nd Number or Rural Route Number, e)
29a. Certifier 1 Certifying Ph (Check 2 Medical Example)	cian: To the best of my er: On the basis of exam	knowledge, death occurre nination and/or investigation	d at the time, date and place, in my opinion, death occurred	and due to the cause(s) at the time, date and place	and manner as stated. e, and due to the cause(s) and manner stated.

Pertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

26516

29d. Date signed (Month. Dav. Year)

DENKK MD 21760

DHMH 17 Rev 06-2011

State Registrar

Medical

only one)

29b. Signature and title

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JUN 0 5 2012

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ompleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year 03:33^M Physician Irdith Ade June 5 2013 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Johns Hopkins Bayview Medical Center **Baltimore** Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 M 2 X 80 219-28-9900 Aug. 28,1931 Maryland **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10h Count shov must be notified at 1 Yes 2 No Director Baltimore County MD Baltimore 28a-f 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ö 7023 Bank St. 23a Funeral United States 21224 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2X Married 2 X No 21215-0036 ò 1 ☐ Yes 2 X No þ Specify: 3 Widowed 4 Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Rusiness/Industry 15. Decedent's Education Medical (Specify only highest grade completed) Crown Cork & Elementary/Secondary (0-12) 12 Years College (1-4 or 5+) d Mental Hygiene. marked other than Seal Corp the Assembly Line Worker uth and Mental Hygi 27 is marked other r traumatic event, ti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be Ida Pearl Thorne William Capp 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 7023 Bank Street Mr. Elvy Adey, Sr. (Husband) Health a other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot once. 1X Burial 2 Cremation 3 Removal from State 6/9/2012 Baltimore, Maryland Oak Lawn Cemetery 4 Donation 5 Other (Specify) 21. Sign were If Funeral Service Licenses ²² Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Part 1. Enter the disease shock, or heart failure of only one cause on each line Onset and Death Immediate Cause (Final Physician ST Myocardial Infarction Elevation hours disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 20 years Coronary arter disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated experts.) Due to for as a consequence on Exami The law requires that the death certificate be executed physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 m Month Year Pregnant at time of death 5 Other (specify) detached f 2 X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ pe adenocaranoma 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy has performed? 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 XInpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 ▼No 2 ER/Outpatient 3 DOA မ funeral 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; 5 Pending investigation After 1 Natural (Month, Day Year) Injury s after death. 1 Yes 2 No 2 Accident the 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 | Homicide City or Town, State) 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: filled in by 24 hours a within 24 hou

To the Funer

completely fi

> State Registrar

10

Jennifer 31. Date filed (Month, Day, Year) MN 0 6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 32. Registrar's Signature

and manner stated.

DHMH 17 Rev 1/2001

(check only one)

29b. Signature and title of certifier

29c. License number AES- 000 29d. Date signed (Month, Day, Year)

June 5, 2012

4940 Eastern Avenue, Baltimore, MD, 21224

12-041	159
Rene	Altiere

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Physician/ 1. Decedent's Name (First, Middle,Last) edical Examiner Rene Jean Altiere 4a. Facility Name (if not institution, give street and number) 1600 Martha Court Unit 403 Bel Air	Reg. No.
4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location	2. Date of Death Month Day Year 1220 hrs
1600 Martha Court Unit 403	Julie 1, 2012
	Harford
runeral ""	Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD
	10d. Inside City Limits
Harford Bo	el Air 1 Yes 2 X No
106. Street and Number 106. Zip Code 1600 Martha Court Unit 403 21015	10g. Citizen of What Country? United States
The state of the s	cican, Puerto Rican, etc.) White, etc.
3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2 No specific rolls 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (G	
15. Decedent's Education (Specify only highest grade completed) Specify only highest grade completed) Total Decedent's during most of working life. Do N Baltimore County	NOT use retired)
The second secon	Law Enforcement other's Name (First, Middle, Maiden Surname)
Police Officer 12 Years 2 Years Police Officer 17. Father's Name (First, Middle, Last) Anthony Altiere 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Informant's Name/Relationship (Type, Print)	Maureen P. Hurley
19a. Informant's Name/Relationship (Type, Print)	Number or Rural Route Number, City or Town, State, Zip Code)
Mr. Anthony Altiere (Father) 7234 Stratton 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery	
1 K Burial 2 Cremation 3 Removal from State crematory or other place) 4 Popper on 5 Other Specify: Oak Lawn Cemetery	6/8/2012 Baltimore, Maryland
20a. Method of Disposition (Name of cemetery crematory or other place) 20b. Place of Disposition (Name of cemetery crematory or other place) 20c. Method of Disposition (Name of cemetery crematory or other place) 20c. Place of Disposition (Name of cemetery crematory or other place) 20c. Place of Disposition (Name of cemetery crematory or other place) 20c. Place of Disposition (Name of cemetery crematory or other place) 20c. Place of Disposition (Name of cemetery crematory or other place) 20c. Place of Disposition (Name of cemetery crematory or other place) 20c. Place of Disposition (Name of cemetery crematory or other place) 20c. Place of Disposition (Name of cemetery crematory or other place)	neral Home of Dundalk, Inc.
Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a	
failure. List only one cause on each line. Immediate Cause (Final disease e. Contact Gunshot Wound of Head	Death
or condition resulting in death) Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Let cause. Enter Underlying Cause	
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): d.	
d. UNPENDED AMENDED We dizario and an experimental and an exper	
1 FFEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ect	23d. Date of delivery topic pregnancy Month Day Year
Decing the part of	
en trade of the conditions of	
duid bec	1 Yes 2 V No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available
The coordinate of the coordina	autopsy prior to completion of cause of performed? death?
25. Was case referred to medical examiner? 1 Ves 2 No Other Control of Deciding 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1 ✓ Yes 2 No 1 ✓ Yes 2 No No
Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other	4 Nursing Home 5 Residence 6 🗹 Other: Scene
28a. Date of Injury 28b. Time of Injury 28c. Injury at W	Nork? 28d. Describe how injury occurred Subject shot self
C signation of the second of t	g, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1600 Martha Court Unit 403, Bel Air, MD
To be seen to be seen	
The state of the s	
The state of the s	
29b. Signature and title of certifier 29c. License num O.C.M.E.	Diper 29d. Date signed (Month, Day, Year) June 2, 2012
29b. Signature and title of certifier 29c. License number 29c. Lic	June 2, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Nellie W. Abner 1 Day Physician/ Honth 6 20 F2 8:14 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 8. Date of Birth Days Hours (Month, Day, Year) 8-28-1921 90 424-22-2752 Director 1 □ M 2X F Ala. Usual Residence of Decedent 3a or 28a-f show t be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director D.C. Washington 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a omnust be Funeral 1758 Lang Pl. N.E. 20002 U.S.A. "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 XWidowed 4 ☐ Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ntal Hygiene. ed other than " Elementary/Secondary (0-12) College (1-4 or 5+) Government Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental h and.

of Health and
If item 27 is marked.

or traumatic et 2 James Williams Ella Mae Carraway 19a. Informant's Name/Relationship (Type, Print)
Robin Morrison (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1758 Lang Pl. N.E. Wash, D.C. 20002 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Date Page 1 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 6-11-2012 Brentwood MD. 4 Donation 5 Other (Specify) Ft. Lincoln Cem. 22. Name and Address of Facility Hunt Funeral Home Signature of Funeral Service Licensee B Hunt 908 Kennedy St. N.W. Wash, D.C. CC373 20011 Tranca 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Metastatic Vulvar Cancer Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last physician s the burial Be Completed by Physician/Medical P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 X No Month Pregnant at time of death Day Year signed by the a 1 ☐ Yes 2 ☑ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 X No 2 🗌 No 1 Yes Division of Vital funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: 힏 1 ☐ Yes 2 💢 No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Hospital or Attending Pt 24 hours after death. Funeral Director: After th Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No filled in by the Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D69916

Registrar
DHMH 17 Rev 06-2011

State

1500 Glen Rd. Siver Spring Md. 20910

person who completed cause of death (Item 23a) (Type, Print)

Wright MD.

Nioke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#SperFH, G928, 6/22/2012, WS State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 27, Year Bloomer 20°12 Bonnie 1215 Vaughan Μ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth July Day, Year) Days Hours Min 212-64-1849 1 M 2 X **Director** 88 1923 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 3a or 28a-f sl MD Montgomery Derwood 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20855 USA 18500 Muncaster Road ural", or items ? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" Completed Specify: White 3X Widowed 4 ☐ Divorced Year or Dates : If item 27 is marked other than "natur or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home and Mental Hygier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Bloomer Tucker Vaughan Laura Fritz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 7308 Damascus Road, Gaithersburg, MD Erma Holmes - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State Adams Cemetery 05-31-2012 Duffield, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Metropolitan Funeral Service 5517 Vine Street, Alexandria, VA Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, A 11 Enter the disease, or complications that cause ock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician massive erebral 0 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of): inding physician ause as the burial Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be 24 hours after death. Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day igned by the at be detached for Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown plnous Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed?

Yes 2 No After this certificate 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death

Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? __1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending iniury Accident Investigation Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) within 24 hours a To the Funeral L Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number May 27, 2012 Rockville, MD 20850 30. Name and address of person who completed cause of death (# 23a) (Type, Print) Zhengqi Wu MD 9901 Medical 31. Date filed (Month) Day, (Month) Day, Year) JUN 0 6 2012 32. Registrar's Signature Registrar

3

21/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ 2012 June 2, 11:30 A M Bora Saraswati Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Burtonsville Montgomery 3905 Cotton Tree Lane Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 216-31-1364 **Director** 1 □ M 2 🗶 F Yrs 66 June 16, 1945 India Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location Director notified 1 ☐ Yes 2 X No Burtonsville Maryland Montgomery 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Examiner must be items 23a Funeral 20866 India 3905 Cotton Tree Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, White, etc. 'natural", or þ 1 Never Married 2 X Married ☐ Yes 2 X No filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: Asian Indian 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked o permit. Page 1 and 2 should be file Department of Health and Mental I Important; If item 27 is marked o any injury or other traumatic evence. မ Jayanti Fartiyal Fartiyal Harsingh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3905 Cotton Tree Lane, Burtonsville, MD 20866 Govind Singh Bora/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date June 4 2012 West Arunder other place) 1 🗌 Burial 2 🔀 Cremation 3 🗀 Removal from State Odenton, Maryland Crematory 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 Will Ersone, M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Phylician Metastatic Cancer colon disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Month Day Year Unknown g Unknow P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 2 🗌 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at work? Certificate: 28d. Describe how injury occurred To the Hospital or Attending 5 Pending Natural injury 1 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) 24 hours Medical

30 State

within 2

To the I

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Registrar DHMH 17 Rev 06-2011 29a. Certifier (Check

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Y. Moy,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M.D.,

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D43260

29d. Date signed (Month, Day, Year) June 4, 2012

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

13952 Baltimore Avenue, Laurel, Maryland 20707

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month **ELIZABETH BRUMBAUGH** LOUISE 5 6:55P June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimroe Baltimore Oak Crest Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Min 214-24-6830 1 🗆 M 2 🕅 F 84 Director Yrs 12/13/1927 Maryland 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland **Funeral Director** Maryland Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 21234 8800 Walther Blvd #4514 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Completed 3 Divorced White Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natun any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Henry Hilton Sause Carolyn Roys 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dale Calvin Brumbaugh Husband 8800 Walther Blvd #4514 Baltimore Maryland 21234 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burlal 2 X Cremation 3 ☐ Removal from State GreenMount Crematory 06/05/2012 Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Fact Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ardio myopathe disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, J Examine if any, leading to immediate Due to (or as a consequence of) burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Dav Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown ed by the a RUMBAUG Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. eral Director: After this certificate has been signed filled in by the funeral director, page 2 should be def 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 Tes 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury 5 Pending 24 hours after death. Funeral Director: A 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical within 24 hou

To the Funer

completely fil 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Dav. Year) man 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boolevard Parkollo MD 21234 Anna <u> SS00</u> walthor Date filed (Month, Day, Year) /32. Registrar's Signature State ENE 2012 JUN 0 6 Registrar DHMH 17 Rev 06 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Bradford, Sr. **Physician** Donald 2012 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, Year)
~i1 18,1942 uare Birthplace (State or Foreign Country) Funeral 1 ☑ M 2 ☐ F 217-38-0812 Maryland 70 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exeminer must be notified at any Injury or other traumatic event, the Medical Exeminer must be notified at any Injury or other traumatic event, the Medical Exeminer must be notified at any Injury or other traumatic event. 1 ☐Yes 2 No Dunda1k Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1956 Guy Way 21222 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ⊠Yes 2 □ No If Yes, Give Year or Date¶: 959–63 1 ☐ Never Married 2 ☑ Married 1 □Yes 2 ☑ No ģ Specify: 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baltimore Gas Elementary/Secondary (0-12) College (1-4or 5+) Electric Company Supervisor 12_Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Myrtle K. Elzey Carl D. Bradford ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dundalk, Maryland 1956 Guy Way Mrs. Rosemarie Bradford(Wife) 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Ht. of Jesus Cem.6/6/2012 Dundalk, Maryland 4 ☐ Donation _ 5 ☐ Other (Specify) Reed 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licensee Gregory 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failurg. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** monic /Medical Due to (or as a consequence of) Examiner nfanction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Exami burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 ☐ Yes 2 100 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 29a, Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 f death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

JUN 0 6 2012

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П	Physicia												Month June	Da	ay 20	Year	3. Time	of Death
111	Medic Examin		Steven F 4a. Facility Name (iii	not institution, g	ive street and num	ber)			4b. City	, Town, or	Location of	of Death	Julie	40	. County		<u>ا م</u>	<u></u>
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	Funeral Director		5. Social Security N 212-86-		. Sex 1 🛣 M 2 □ F	7. Age (Ir	n yrs. last		Months Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth a <i>y</i> , Yea <i>r)</i>		9. Birthp Coun		e or Foreign
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	with the 23a c	Funeral		ind Rid	ge Rd.					2177	1			70g. O		SA	, .	
36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status	ied 2 🛭 Marrie	12. Was Decedor Armed For 1 Yes If Yes, Give	ces? 2 X No		1		dent of His cify Cubar			cify Yes or No Rican, etc.)	••	14. Race	e - Americ k, White,	an Indian, etc. ite	
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Bal	permit. Page 1 Department of Important: If i any injury or conce.		21. Signature of Fu	neral Service Vic	ensee	/							ral Ho					
			23a. Part 1. Enter	the disease, or co	omplications that of	aused the	e death. [TIET	u _ m	Approxin	nate
-4	Physician/		Immediate Cause disease or condition	Final	y one cause on ea	ch line.	١.,	chola	were.	ence	inom	es.					Onset an	
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Box	Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death certificate be 34 hours after death careful pricedor After. This certificate has been signed by the attending physiciately filled in by the funeral director, page 2 should be detached for use as the but tilled in by the funeral director, page 2 should be detached for use as the but after the page 2 should be detached for use as the but after the page 2 should be detached for use as the but after the page 2 should be detached for use as the but after the page 3 should be detached for use as the page 3 should be detached for use as the page 3 should be detached for use as the page 3 should be 3 should be 3 should be 3 should be 3 should be 4 s	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 [9 ☐ Unknown	months?	23c. If yes, out 1 ☐ Live I 4 ☐ Pregi 9 ☐ Unkn	Birth 2 [nant at tir	Fetal d	eath 3	Ectopic Other (s		у				23d. Dat Mor	e of deliventh	ery Day	Year
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<u>Xi</u>	Physician; T this certifica ral director, p	မ	1 🗌 Yes 2	No				?/Outpatier		Othe	er: 4 🗌 No	ursing Ho	me 5 🗆 Res	idence (6 Othe	CAI r (Specify	ricili C	ounly
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Divis	e Hospital or Attendin n 24 hours after death. e Funeral Director Aft eletely filled n by the fur	al Cert	4 Homicide	determine	ed 28e. Place buildir	ng, etc. (S	Specify)						28f. Location (City or To	wn, State	=)			mber,
	To the Hosp within 24 hou To the Funer completely fi	Medical	(Check 2 only one) 3	☐ Medical Exa ☐ Certifying N	hysician: To the basininer: On the basinse Practitioner:	is of exam	nination ar est of my l	nd/or invest knowledge,	tigation, in , death occ	my opinio curred at th	n, death od ne time, da	ccurred at te and pla	the time, date ce, and due to	and place the caus	e, and due e(s) and m	to the car anner as	use(s) and stated.	3.7
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	121		30. Name and addr	AF. Pap	oi DG.	98	h (Item 23	Ba) (Type, F	Print) Stree	t, Su	ite 24	8, 1	Dunas	٧٤,	MD	20	812	
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amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Year Nancy Lee Beck 10:50 P. M Medical 2012 une 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Hospital If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Month, Day 936 Days Hours Min. Director 213-34-1349 1 M 2 X F Yrs 75 08-29-Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be a once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 301 Linda Avenue 21090 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 XXMarried Completed by 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Marshall Winchester Van Horne Helen R. Shaffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Beck - spouse Linda Avenue, Linthicum, Maryland 21090 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Meadowridge Mem Park | 06-07-2012 Elkridge, Maryland 21. Sign vul of Funeral Service L 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc, 7250 Wash Blvd, Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ 966 Peritonity from infestinal leallage disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to for as a consequence on cause. Enter Underlying Cause (Disease or injury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the 38 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) attending IF FEMALE use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No detached for Month Day Year 4 Pregnant : 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ (crical Completed 1 ☐ Yes 2 MNo 3 ☐ Probably 4 ☐ Unknown page 2 should Diabetes Mellitus, 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No Hyputhurvidism within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, paging the funeral director, paging the funeral director, paging the funeral director, paging the funeral director, paging the funeral director, paging the funeral director, paging the funeral director, paging the funeral director, paging the funeral director, paging the funeral director of the funeral director of the funeral director of the function of the functio 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗹 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural iniury 5 Pending Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 0 00 6 5 000 29d. Date signed (Month, Day, Year) Whi h- work MD June 3 2012 P 25910 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Biltimore, MD 21229 900 Williams (xton Avenue 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day JOHN ROBERT BAILEY JUNE 2012 9:45 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death MANOR CARE TOWSON TOWSON BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 ★ M 2 □ F Months Days Hours 81 220-24-6301 7/25/1930 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No BALTIMORE TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1632 NATURO ROAD 21286 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

\$

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it. Modical Evat.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit ficate has been siç ; page 2 shoufd b

Division of Vital Records, P.O. Box 68760, Regist

Complete	15. Decedent's Edu (Specify only highest grad	le completed)	16a. Decedent's Usu (Give kind of wo life. DO NOT u	ork done during most of world		Kind of Business/Indus	stry
mo	Elementary/Secondary (0-12) 12TH GRADE	College (1-4or 5+)	SALESMAN	·	J	. MARTIN C	HRIS
Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	ne (First, Middle, Maide	en Surname)	·
2	DANIEL BAILEY			VIOLA	WALKER		
	19a. Informant's Name/Relationship (7)	/pe. Print)	19b. Mailing Address	(Street and Number or Ru	ral Route Number, City	or Town, State, Zip C	ode)
	ADDIE BAILEY/WIFE	2	1632 NATI	JRO ROAD TOW	SON, MD 2	1286	
	20a. Method of Disposition ▼XBurial 2 □ Cremation 3 □ F	Computal from State	Place of Disposition (National Place of Disposition (National Place)	me of other place)		Location - City or Town	n, State
	4 □ Donation 5 □ Other (Specify)		ANEY VALLEY	0///	2012 CO	CKEYSVILLE	, MD
	21. Signature of Funeral Servic Licens	- 4/10/139 -		nd Address of Facility TH			
	23a Part 1. Enter the disease, or composition of the shock, or heart failure. List only o	ications that caused the death	n. Do not enter the mod	de of dying, such as cardiac	or respiratory arrest,	Ir	pproximate nterval Between
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ian	in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal	I death 3 🗌 Ectopic p			23d. Date of delivery Month Date	
ysic	1 ☐Yes 2 ☐No 9 ☐ Unknown	4 ☐ Pregnant at time of d 9 ☐ Unknown	leath 5 ☐ Other (s _i	oecity)			,
Completed by Physician/Medical Examiner	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the underlying o	ause given in Part I.	23e. Did tobacco	use contribute to the	cause of death?
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ם					autopsy performed?	prior to comp	pletion of cause of
ပိ	25. Was case referred to medical				1 □ Yes 2 🔀		□No
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ig	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No		,	
lica	3 Suicide 6 Could not be	28e. Place of Injury - At ho	ome, farm, street, factor		28f. Location (Street	and Number or Rural F	Route Number,
Certification: To	4 Homicide determined	building, etc. (Specify	<i>y)</i>		City or Town, Sta	ite)	
alC	29a. Certifier 1 Certifying Phy	sician: To the best of my kno	wledge, death occurred	at the time, date and place	, and due to the cause	(s) and manner as sta	ted.
edical	(Check only 2 Medical Exam	iner: On the basis of examina and manner stated.	ition and/or investigation	n, in my opinion, death occu	rred at the time, date a	ind place, and due to th	ne cause(s)
M	29b. Signature and title of certifier	21		c. License number		Date signed (Month, Da	
	11110	4 laeur		0-12849		6-4-12	-
	30. Name and address of person who co	ompleted cause of death (Item	n 23a) (Type, Print)				7 /
	AH GHILADI.			ER Dr. 1	OWSON	MO	21204
te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture facts	9			
ar	JUN 0 6 2	UIZ Jeneva	h. 19				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 20 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Michael Luther E Burgess Month 20192 2 29A M UNE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death BACIMORE WASHINGTON MEDICAL CENTE GLEN +SUPNIE ARUNDEL FIRME Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 12/28/1949 Months Hours 219-52-3971 1 XM 2 □ F 62 Director MD Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Anne Arundel MD Linthicum 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be Funeral 21090 USA 909 Lynvue Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates MICHAR 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working d Mental Hygiene. marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ADP Payroll Driver <u>2yrs</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Helen Smith Franklin Burgess 19a. Informant's Name/Relationship (Type, Print) Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Ramona Michele Burgess Lynvue RD Linthicum MD 21090 909 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date . Page 1 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Atlantic Crem 6/4/2012 Glen Burnie MD 22. Name and Address of Facility Simplicity Crem & Fun Serv Signature of Funeral Service Licenses noms ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ -1~150H35 DKEASE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami burial-trar and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 as the L IF FEMALE Jse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 4 ☐ Pregnant : 9 ☐ Unknown 1 ☐ Yes 2 L 9 ☐ Unknown the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has autopsy performed 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner?
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2 Accident
3 Suicide
4 Homicide injury 5 Pending death. Investigation filled in by the within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20161 32. Registrar's Signature State Registrar

			For	State of M	aryland		artment of H		d Mental			1.0	170	20
			State Registrar			Cer	tificate of D	Death			No. 20	12	1/6	339
п	Physicia	n/	1. Decedent's Name (First, Midd.						2. Date of Month		Day	Year	3. Time of D	
,-***a,-	Medic	al	Edwin 4a. Facility Name (if not institution	F. Bjoro, J	r.		4b. City, Town, or	Location of Do		e 3,	2012 4c. County	of Dooth	8:40	A N
	Examin	er	Brinton Woods		ehab		Sykesvi		zaui		Carro			
	Funeral		5. Social Security Number			st birthday)	If Under 1 Year Months Days	If Under 24 H		of Birth	irth 9. Birthplace (Sta			Foreign
	Director		350-20-3531	1 🖾 M 2 🗆 F	83	Yrs.	World Days	Tiodis I W	Nov.			I111		
	nd thow	jo.	Usual Residence of Decedent 10a. State 10b. County	,		, Town or Loc	ation	L	L				0d. Inside City	Limits
	Aaryla 8a-f s tified	Director	FL Sara	asota		Veni	ce						1 🗆 Yes 2	⊠ No
	the Na or 2		10e. Street and Number	D	-		10f. Zip Code 34292				Citizen of W	/hat Coun	try?	
	h with	Funeral	1943 Beatello								SA			
	r deat		11. Marital Status1 ☐ Never Married 2 ☐ Ma	12. Was Decedent Armed Forces?			Vas Decedent of Hi Yes, specify Cuba					e - America k, White, e		
036	s after ral", c	Completed by	3 X Widowed 4 ☐ Divorce	200	INO	1	☐ Yes 2 🕅 No	Specify:			Specify:	V	Thite	
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121	thin 7%	mo	Elementary/Secondary (0-12)	College (1-4 or	5+)	life. DO	O NOT use retired)	aring most or i	· or in g	C	D-		_	
9	ed wil Hygie other ent, th	d)	17. Father's Name (First, Middle,	5+ 	1	Engi	neer	18 Mother's N	Name (First, Mid		ace Pr		IH	
Maryland 21215-0036	be fill lental rked ric ev	2	Edwin F. Bj						nce (un					
ary	should and N is ma		19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailin	g Address (Street a	and Number or	Rural Route Nu	ımber, City	y or Town, St	tate, Zip C	ode)	- //
Σ	ealth m 27		Michael Bjoro	Son			anglewoo	d Drive	; Syke	svill	e, MD	2178	34	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation	3 Removal from State	l ce	emetery crem	sition (Name of natory or other plac	e) 4/5	Date /2012		Location -	•		
Him	it. Pag intmer intant njury		4 Donation 5 Other		ALI		Crematory				len Bu			ρ.
Ba	permit Depar Impor any ir		21. Signature of Funeral Service	Licentine		Fu	Name and Address nerel Ho 30 Edmon	me of C dsor Av	Catonsvi	ille, Caton	Inc.	e. MT	21228	
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- X-an	Physician/		Immediate Cause (Final disease or condition	Cer	ober 19	xular	Dislas	P				2	Onset and De	
Sept.	Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):								
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a conseque	ence of):								1
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8	execu an an	dical Examiner	that initiated events resulting in death) Last	Due to (or as	a conseque	ence of):								
09	tte be hysicii the bu	dica		d						·				
687	ertifica ding p	/Me	IF FEMALE:	23c. If ves, outcome	of pregnar	201								
Box (death certificate be executed he attending physician and ted for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal	Ideath 3 🗌	Ectopic pregnanc Other (specify)	У			23d. Date Mor	e of delive nth	ry Day Yea	ar
Ö.	e e e	hysi	1 Yes 2 No 9 Unknown	9 🗆 Unknown										
P.O.	es that the dea signed by the a I be detached f	by P	Part II. Other significant condit	ons contributing to death t	out not resu	ulting in the u	nderlying cause giv	ren in Part I.	23e. I	Did tobaco	co use contri	bute to th	e cause of dea	th?
ds,	requires been sig should b	ted							-	☐ Yes	2 No	3 🗌 Prob	ably 4 🖰 Ur	known
COL	has be	Completed							_ ;	Was an autopsy	_ P	rior to cor	sy findings ava	ailable ise of
Re	; The la cate ha ; page								1 🗆	performed Yes 2		leath?	2 🗆 No	
ital	ysician; is certifica director,	Be c	25. Was case referred to medica examiner? 1 Yes 2 No	Hospital:			Othe	ace of Death (C						
of V	ding Phys h. After this funeral d	e; To	27. Manne of Death	28a. Date of inju	iry	ER/Outpatien 28b. Time of	28c. Injury	/ at	g Home 5 1		e 6 □ Othe njury occurre			
no	nding ath. r: Afte ne fun	icat		igation	y, Year)	injury	M 1 🗆	? Yes 2 □ No						
Division of Vital Records,	r Atte ter de irecto	Certificate:	3 Suicide 6 Could 4 Homicide deter		ury - At hor	me, farm, stre	et, factory, office			on (Street r Town, St		r or Rural	Route Number	
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	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach	Medical	(Check 2 Medical	g Physician: To the best of Examiner: On the busis of e https://www.fracybloner.Tottl	xamination	and/or invest	igation, in my opinio	n, death occurre	ed at the time, d	late and pla	ace, and due	to the cau	ise(s) and mann	er stated.
	To the To the Comp	-	29b. Signature and title of certific	- //		, , , , , , , , , , , , , , , , , , , ,	29c. License				Date signed			
	, 1		Jebel 18	(Mesus			050	0806		6	141	12		
	54		30. Name and address of person	who completed cause of c		23a) (Type, P		= Dr	Reisi	eis/a	u N	D.	21136	
20	Stat Registra	te	/	012 32. Registr	ar's Sic. ratu	ure park	4	70.	/					
	negistra	31	0011000	1	-	*/								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 5:53 AM 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** B 02 2004 0 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days | Hours | Min. | Nov. 25, 1937 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 216-34-4418 1 □ M 2 🕱 F 74 Maryland Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Expander must be notified at Baltimore X 1 ☐ Yes 2 ☐ No MD Director the 10f. Zip Code 21230 10g. Citizen of What Country? 10e. Street and Number 2125 Annapolis Rd Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc filed within 72 hours after Hygiene. ∐Yes 2 X No fYes. Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Tyes 2 No Specify: þ White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Walbelly 17. Father's Name (First, Middle, Last) 2 should be fi and Mental F Oscar Moeller ဂ္ 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code) 2125 Annapolis Rd Baltimore, MD 21230 permit. Pages 1 and 2 she Department of Health and Important: If item 27 is m any injury or other traum 19a. Informant's Name/Relationship (Type. Print) William Pumphrey Pages 1 (ment of H) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery crematory or other place)
Cedar Hill Cemetery 1 Burial 2 □ Cremation 3 □ Removal from State June 6, 2012 Brooklyn Park, MD 4 ☐ Donation _ 5 ☐ Other (Specify) 22. Name and Address of Facility Polymiak Funeral Hone F.A. 21. Signature of Funer 1 Service-Licensee 130 East Fort Avenue Baltimore, MD 21230 1270 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ovascu disease or condition resulting in death) hesoich D /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Directo for an in-numeroperate offlaw requires that the death certificate be executed burial-tran and Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy ρ in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Waş an autopsy performed? Yes 2000 To the Hospital or Attending Physician: The lwitin 24 hours after death.

To the Funeral Director: After this certificate ha 1 ☐Yes 2 ☐No 1 ☐ Yes After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 R/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 2 ☐ Accident 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 5 Pending investigation thours after death.

uneral Director: Aftely filled in by the fun 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Ye

32. Registrar's Signature

1. pares

		State of Maryland / Department of Health and I	Mental Hyg	giene 2012	17841
		Registrar Certificate of Death		Reg. No. ZUIZ	17041
Physicia Medic			2. Date of Deat Month June	2, 2012	3. Time of Death 10:09AM
Examir			1	4c. County of Death	George's
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
Director		605-02-6003 1 □ M 2XXF 65 Yrs. Willing Days Flours	(Month, Day, Aug 8,		lippines
and show	ō		inag or		10d. Inside City Limits
Maryl: 28a-f otiffied	rect	MD Prince George's Laurel			1 XXes 2 □ No
h the	alD	10e. Street and Number 10f. Zip Code		10g. Citizen of What Cou	ntry?
ath wif	Funeral Director	15607 Birch Run Terrace 20707 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	:6.1/1	U.S.A.	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygien. Important: If item 27 is marked other than "natural", or items 29a or 28a-f show any injury or other traumatic event, the Me Ical Examiner must be notified at once.	ρ	1 Never Married 2 Married 2 Married 1 Never Married 2 Married 3 Married 2 Married 3 Marrie	Rican, etc.)	14. Race - Americ Black, White, Specify: AS	
atura	etec	3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation			
21215-0036 within 72 hours after giene, ner than "natural", o t, the Me ical Exam	Completed	(Specify only highest grade completed) (Give kind of work done during most of work life, DO NOT use retired) (Give kind of work done during most of work life, DO NOT use retired)	king	16b. Kind of Business/In	dustry
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and be filed ntal H sed of	년 B	0 - 2 0	ne (First, Middle, N	-	
aryl lould b		19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Malling Address (<i>Street and Number or Run</i>	Arriola		Cadal
d2sh d2sh alth al n27 is		Arturo C. Caraan / Spouse 15607 Birch Run Terra		el, Marylan	
Baltimore, Maryland permit. Page 1 and 2 should be filed Department of Health and Mental Hy important: If item 27 is marked oth any injury or other traumatic event once.		20g Method of Disposition		20c. Location - City or To	
timent trant: tant:		4 Donation 5 Other (Specify) Md. National Mem. Pk. 6/9,	/2012	Laurel, Ma	ryland
Bal permit Depar Impor any in		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral 313 Talbott Avenue	l Home, i	P.A. ei, Marylan	d 20707
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arre	est,	Approximate Interval Between
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6876 sertificate rding phy use as th	Med	IF FEMALE:			
th cer ttendii	ian/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1		23d. Date of deliver	'
Records, P.O. Box 68760 The law requires that the death certificate be ex ate has been signed by the attending physician page 2 should be detached for use as the burian	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown		WORL	Day Year
P.O.	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	pacco use contribute to the	ne cause of death?
ds, quires en sig ould b	ted	Acute Renal Failure	1 □ Ye	es 2 No 3 🗆 Prol	oably 4 🗆 Unknown
law re	Completed by	Diabetes Mellitus	24a. Was ar autops	y prior to co	osy findings available mpletion of cause of
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Hospit 24 hour Funera etely filk	edical	29a. Certifier (Check 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time.	t the time, date and	d place, and due to the car	ise(s) and manner stated.
To th∉ within To the compl	Σ	only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place 29b. Signature and title of certifier 29c. License number		e cause(s) and manner as s 9d. Date signed (Month, l	
		Meger Air, MD D69430		June 2,	2012
2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	00 Van I	Dusen Roa	d
V Stat	e	Nega Ali Goji, MD Laurel Regional Hospital Laurel 31. Date filed (Month; Day, Year) 32. pegistrar's Signatur	urel, 1	1D 2070)' <i> </i>
Registra		JUN 0 6 2012 Suma B. Jacks			
DHMH 17 Pay 06-2					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 17842 For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Talma C. Caudill 20PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City Town, or Location of Death 4c. County of Death werlieu 350 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, **Funeral** Birthplace (State or Foreign Months Days Hours Min 231-03-9779 Director 1 M 2X F 2,1919 Virginia 92 Yrs Nov. permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified any injury or other traumatic event, the Medical Examiner must he notified any injury or other traumatic event, the Medical Examiner must he notified any injury or other traumatic event, the Medical Examiner must he notified any injury or other traumatic event, the Medical Examiner must be notified any injury or other traumatic event, the Medical Examiner must be notified any injury or other traumatic event, the Maryland and injury or other traumatic event, the Maryland and injury or other traumatic event. 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Dunda1k MDBaltimore 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7913 Trappe Road Apt. C 21222 United States 12. Was Decedent Ever in U.S. Was Deceuc... Armed Forces? Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc <u>\$</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White Completed 3X Widowed 4 Divorced Specify 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 11 Years College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Katherine Wiley Harry L. Quarles 19a. Informant's Name/Relationship (Type, Print)
Mr. William F. Caudill (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 241 Tom Lucas Lane Pelion, SC 29123 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XL $\acute{\text{B}}$ urial 2 \square Cremation 3 \square Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/6/2012 Middle River, MD Hill Mem. Gdns. Funeral Service License Gregory 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Reed 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complication shock, or heartifullure test only one cause complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death on each line. Immediate Cause (Final Phy ician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine Due to (or as - onsequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Year Day Pregnant at time of death been signed by the Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 Unknown should ! 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 XNo after death.

Director: After this certificate 1 Yes 2 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospita 2 X No ပု 1 Tes Other 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify Manner of Death Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 2 No ☐ Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 6666 Name and address of person who completed cause of death (Item 23a) (Type State Registrar

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]	Registrar				Cei	rtificat	e of D	eath			Reg. N	0. 6	116	1/	043
и	Physicia Medic		Decedent's Name (First, Mide		James D	udley Cle	ndinen	<i></i>			_	2. Date of De Month 05	D	ay ()	Year 2012	3. Time o	
	Examin		4a. Facility Name (if not institution	on, give str	reet and numb	ber)		4b. City,	, Town, or	Location	of Death		4	c. County	y of Death		
			Joseph Ritchie I						- 4 14	Baltin							
	Funeral Director		5. Social Security Number 264-72-6718	6. Sex	M 2 □ F	7. Age (In yrs. 6		Months 1	Days	tf Under Hours	Min.	8. Date of Bir (Month, Da 08/17	th ry, Yea <i>r)</i> //194	4	9. Birthp Coun	lace (State try) Florida	or Foreign
	od at	5	Usual Residence of Decedent 10a. State 10b. Coun	ty		10c. Ci	ty, Town or Lo	cation							1	0d. Inside C	City Limits
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>>-	with s 23a	Funeral Director	100 W. University	Parkw	av, Apt.	2C				2121	10				USA		
Ω	leath Items er m	ᇤ	11. Marital Status			dent Ever in U.	.S. 13.	Was Dece	dent of Hi	spanic Ori	igin? (Spec	cify Yes or No- Rican, etc.)			ce - Americ		
38	permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by	1 ☐ Never Married 2 ☐ M 3 ☐ Widowed 4 ☐ Divorce		1 Yes If Yes, Give Year or Dat	2 X No	- 1	1 ☐ Yes						Specify	r.	hite	
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0 7	mari		19a. Informant's Name/Relatio			umen	19b. Mail	ng Addres	is (Street a	and Numb	er or Rura	I Route Numbe				Code)	
m \ \vec{\vec{\vec{\vec{\vec{\vec{\vec{	d 2 shalth an 27 is		Whitney Barritt Cle	ndinen	/ Daught	er		•				Silver Spr					
~~ē,	1 and 1 and 1 tem	ecd.	20a. Method of Disposition	-		20b.	Place of Disp cemetery, cre	osition (Na	me of			Date			- City or To	wn, State	
S E	Page nent c ant: If ary or		1 ☐ Burial 2 📉 Cremation 4 ☐ Donation 5 ☐ Othe			State	Chesape	-			6/1/	2012		Ве	eltsville	, MD	
⊗ Balti	permit. Departi Import any inj		21. Signature of Funeral Service	e Licensee	B 0 (C	M. d	1 2	2. Name a	nd Addres	ss of Facili	ity		-				
	20 E # 9	Ц	Dorota Marshall	1)	icle h	· waish	wh					ices, PO I		413 B	altimor		
\geq			23a. Part 1. Enter the disease, shock, or heart failure. Lis	or compli- t only one	cations that c	aused the dea ch line.	ath. Do not en		0.0				rrest,			Approxima Interval Be Onset and	etween
U-L	Physician/ • Medical		Immediate Cause (Final disease or condition resulting in death)	a a	FIM	yoro	phie	Late	al	Scle	ROS	ils.			\rightarrow	1-/2	yes
3	Examiner				Due to (as a consul	tuerice oi).										/
7	D to	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Į	Due to (or as a consec	quence of):										
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) 68760	cate physis the	ledi			J												
7,88	certif anding use a	an/N	IF FEMALE: 23b. Was decedent pregnant	23	3c. If yes, out	come of pregn Birth 2 Fe	nancy tal death 3	□ Ectonic	negnang	nv.				23d. D	ate of deliv	ery	
Box	death certificate the attending physied for use as the	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			nant at time of		Other (s						М	lonth	Day	Year
>0	that the ned by the detach	Phy	Part II. Other significant cond	îtions con	ntributing to de	eath but not re	esulting in the	underlying	cause gir	ven in Pari	t i.	23e. Did	tobacco	use con	tribute to t	ne cause of	death?
Da.	requires th been signe should be o	Completed by Physician/Medi										1 🗆	Yes	2 N 0	3 🗌 Pro	bably 4 □	Unknown
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	lan: T rtifica ctor, p	Be C	25. Was case referred to medic examiner?	_					26. PI	lace of De	ath (Check				121		1
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on of	nding Path. r: After the funers	Certificate:	27. Manner of Death 1 2 Natural 5 Per 2 Accident Inve	ding stigation	28a. Date (Mont	of injury th, Day, Year)	28b. Time of injury	of M	28c. Injur work 1 🗆	yat k? Yes 2.[- 1	28d. Describe	how inj	ury occu	rred		
│ Division of Vita	l or Atte after de Directo d in by th			uld not be ermined	28e. Place	of Injury - At I		reet, facto	ry, office			28f. Location (City or To			ber or Rura	l Route Nun	nber,
ы	To the Hospital or Attending Physician: The law requires that the death certificate E within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the funeral director.	Medical	(Check 2 Medic	al Examin	er: On the bas	sis of examinati	ion and/or inve	stigation, ir	n my opinie	on, death o	occurred at	nd due to the of the time, date ace, and due to	and pla	ce, and d	ue to the ca	use(s) and n	nanner stated.
	To the To the To the Comp	2	29b. Signature and title of cert		' - d - d	TTT	A CONTROL			e number	ato and pre				ed (Mgnth,		
			> Jeellille	W	evay	1) 111/4	ソ		D3.	340	0	- E	0	5/3	0/20	212	
	21		30. Name of address of pers	lehe	ompleted caus	se of death (Ite	m 23a) (Type,	Print)	rles	Street	et, 1	Baltim	ar	MO	217	212	
	Sta Registra		31. Date filed (Youth, 6ay 20	2 /	Engil. P	egistra s Sign	parke										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#%PERFH, G930, 8/23/2012, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 20 7844 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201^{ear} Daniel Joseph Cashman, Jr. 11:55A M May Medical 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner Gilchrist Hospice Columbia Howard 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 058-26-8339 8. Date of Birth **Funeral** (Month, Day, Year) Months Days Hours Min Director 1 X M 2 🗆 F Vrs 79 11-4-1932 New York ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Catonsville 10e Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 717 Maiden Choice Lane ST621 21228 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in LLS 14. Race - American Indian, Armed Forces?

Yes 2 \sum No Black, White, etc. by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: r than "natural", the Medical Exar Specify: 3 X Widowed 4 □ Divorced Navy White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 h and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other til any injury or other traumatic event, the once. Administrator Social Security Admin Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Daniel Joseph Cashman, Sr. Teresa McGrath 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Cashman (Sister) 719 Maiden Choice Lane Catonsville, MD 21228 HR404 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State St. Louis Church Cem. 6-7-2012 Clarksville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Witzke Funeral Homes, Inc. 22. Name and Address of Facility Ma123 5555 Twin Knolls Road Columbia, MD 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final 9LIOBLASTOMA Physician/ MULTIFORME disease or condition resulting in death) MONTHS Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if cause. Enter Underlying Cause (Disease or injury Examiner Due to lor as a consequence of physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 as 1 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) the attending IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year 1 Yes 2 L 9 Unknown 9 I Inknown P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CORONARY ARTERY DISEASE Records, 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of DEMENTIA 24a. Was an has autopsy death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 ☐ Yes 2 X No Other: မြ HOSPICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗶 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 1 Natural 28d. Describe how injury occurred injury 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 164395 MAY 31, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6336 CEDAR LANE COLUMBIA, MD 21044 DANIEUE DOBERMAN, MO

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-04048 State of Maryland / Department of Health and Mental Hygiene Joyce Norene Doty 2012 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month Day May 28, 2012 1445 hrs Joyce Norene Doty **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7601 Merritt Point Road Dundalk **Baltimore County** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY **Funeral** Hours Months Director Country) Ohio 295-62-0225 1 M 2 X F 55 11-19-1956 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County Maryland Baltimore 1 Yes 2 No Dundalk Baltimore, MD 21215-UU30 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f she "item var after traumatic event, the Medical Examiner must be notified at once Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 7601 Merritt Point Road 21222 U.S.A. 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married Specify: White If Yes, Give Yaa 1 Yes 2 X No specify: 3 Widowed 4 Divorced 至 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) 12 Tank Mechanic Military 17. Father's Name (First, Middle, Last)
David Doty 18.Mother's Name (First, Middle, Maiden Surname) Mardalene Geiger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Tom Doty: Brother 180 East Jefferson Street, Bluffton, Ohio 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place; 1 Burial 2 K Cremation 3 Removal from State Ardent Cremation, Inc. 6-1-12 Hanover, Maryland 4 Donation 5 Other Specify 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licenses michael 6009 Harford Road, Baltimore, Maryland 21214 marsu 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Amittriptyline Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and ca AMENDED 23a, 27, 28a-f, per me, g928 6-8-12 sm X UNPENDED ned by the attending physician detached for use as the burial Physician/Medi Box 68760, 23d. Date of delivery IE FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 2 Fetal death Day 1 Live birth 3 Ectopic pregnancy Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. Part II. Other significant conditions Š 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed has been si 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? 1 Yes certificate ✓ Yes 2 No 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Be examiner? Hospital: 1 Inpatient Other 4 Nursing Home 5 Residence 6 🗸 Other: Scene 2 ER/Outpatient 3 DOA 1 🗸 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 1 Natural 1 Yes 2 X No unknown Pending fd 5-28-12 fd 14:35 pm Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be Suicide or Town, State) Unknown Single Family Home Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier May 29, 2012 OCME tel Univ 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Carol H. Allan, MD 31. Date filed (Month, Day Year) State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 6 Physician/ 2012 5:30 A M Ruth Eisenstadt Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville Hebrew Home of Greater Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** New York Days (Month, Day, Year 3-19-192 1 M 2 X F Hours 85 Director 578-28-7667 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland Director MD Montgomery Silver Spring 1 X Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 20910 8918 First Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Yes, 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) pernit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Legal Publishing Office Supervisor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gussie Shester ၉ (Unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Michael Eisenstadt - Son 8918 First Avenue, Silver Spring, Maryland 20910 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State King David Mem. Park: 6-7-2012 Falls, Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Edward Sagel Funeral Direction . Signature of Funeral Service Licens Ldward Sage 1 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed s been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death 1 Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? After this certificate has page 2 s performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) ٥ 30. Name and address of person who completed cause of death (Item 23a) (Type Frint) 6/21 MONTRUSE RD.

Registrar

State

31. Date filed (Month, Day, Year,

JUN 0 6

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May Margaret Edom 1:09 30^y 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year) 419-32-5148 **Director** 1 M 2 X F Yrs. 90 2 1921 Alabama Usual Residence of Decedent ms 23a or 28a-f show must be notified at Oa. State 10h Count 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Silver Spring MD 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 12808 Saddle Brook Drive death with 20906 USA items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14 Race - American Indian Examiner Armed Forces?

1 Yes 2 No If Yes, Give or. Black, White, etc. þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Specify: Black 3 X Widowed 4 ☐ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 72 al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) House Wife Private 9th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o ည Jesse Jones Clyde Ragland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906and 2 s Health Diann Richardson Cooper/Daughtet 12808 Saddle Brook Drive, Silver Spring, MD item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 06/11/2012 Hyattsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Harmony Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Road, Hyattsville, Maryland 20785 lano 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each like leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Ph. sician Sepsis with septic shock Medical Due to (or as a consequence of): Examiner Clostridrum Difficile Colitis Sequentially list conditions Examine Due to for as a consequence of if any, leading to immedicause. Enter Underlying Cause (Disease or injury and -trans that initiated events resulting in death) Last Due to (or as a consequence of) physician a s the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \(\subseteq \text{ No} \) for 5 Other (specify) Month Year Pregnant at time of death ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been sig 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed Alzheimer's Dementia 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page performed?

1 Yes 2 No Hypothyroidism 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \sum Yes 2 \boldsymbol{X} \sum No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 🕅 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely fi the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D52503 MAY 30 2012 30. Name and address of person with completed cause of death (Item 23a) (Type, Print) 5 SHAILESH SHETH MD 1500 FOREST GLEN ROAD SILVER SPRING, MARYLAND 20910

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year) -- · ·

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201^{Year} Ella Mae Fleishell June 4, 10:00 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Dove House Westminster Carroll 5. Social Security Number 6. Sex If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs, last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 578-14-2594 **Director** 1 - M 2XX F 99 12/3/2012 MD or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes XX No MD Carroll Sykesville ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 1401 Fannie Dorsey 21784 United States Rd. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 Yes 2 X No Specify Specify: White XXWidowed 4 □ Divorced Completed other than "natu vent, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Food Service Holy Name College Be event. permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event one. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 George Slagle Dorsey Grace Violet Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John R. Fleishell 1401 Fannie Dorsey Rd. Sykesville, MD 21784 (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1

■ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) Carroll Crematory 6/6/2012 4 Donation 5 Other (Specify) Sykesville, MD Signature of Funeral Burrier-Queen Funeral Home and Crematory, P.A. 1212 W. Old Liberty Rd. Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ta Extero Physician/ MORALLEN disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to for as a consequence of If any Insuing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death the be detached Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24a. Was an 24b. Were autopsy findings available has page 2 autopsy prior to completion of eause of death? performed certificate 2 LINO 1 Yes 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 2 🗹 No Other: 1 Yes Certificate: To 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident ✓ Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: / Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of 29d. Date signed (Month, Day, Year) 2012 0006 ille seul 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 101 KUSI 4055 ken

State

31. Date filed (Month, Day, Year)

JUN 0 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mona Emery James Gladney 05 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City. Town, or Location of Death 3916 Hayward Ave. Baltimore Social Security Number If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Director 217-78-1461 1**X** M 2 □ F 53 06/04/1958 Maryland 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 28a-f Maryland Baltimore 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 3916 Hayward Ave. 21215 USA 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-'natural", or iter dical Examiner 14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. þ Black, White, etc. 1 Never Married 2 Married Yes Yes, Give Maryland 21215-0036 2X No 1 ☐ Yes 2 No Specify: 3 🗆 Widowed 4 🔀 Divorced Completed Specify: Black Year or Dates Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Self Employed 12th grade Auto Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I Robert Gladney Gwendolyn Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health sitem 27 i Gwendolyn Inman/Mother 3916 Hayward Ave.Baltimore MD.21215 3altimore, 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place 9 Department Important: If any injury or 05/29/12 DUNDALK MD. Trinity Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Fineral Home 5240 Reisterstown Rd.Baltimore MD.21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) lon Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause Unsease or injury Due to (or as a consequence of): burial-trai that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 as the l yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death use 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Day signed by the ar 1 ☐ Yes ∠ ☐ Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has autonsy 1 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🗆 Yes 2 No မ Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) completely filled in by the funeral 28a. Date of injury (Month, Day, Year) ie Hospital or Attending Pl n 24 hours after death. ie Funeral Director: After th Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 1 Tes 6 [Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 06-2011

completed cause of death (Item 23a) (Type, Print)

	1	For State Registrar 1. Decedent's Name (First, Middle, L	State of Mar		rtificate of			2. Date of De	Reg. No. 2	0 2 78
Physicia Medic Examin	al	Barbara Jean Gi	ve street and number)		4b. City, Town,			Month 5	30 4c. Cou	2012 11:45 A
Funeral Director		Holy Cross Hosp 5. Social Security Number 266-40-5550		n yrs. last birthday)	Silver If Under 1 Yea Months Days	r_ If Unde		8. Date of Birt (Month, Da	th	9. Birthplace (State or Fo
>	tor	Usual Residence of Decedent 10a. State 10b. County	11	Oc. City, Town or Lo				2-27-1	931	10d. Inside City Li
. 23a or 28a-f shov ust be notified at	Funeral Director	MD Montgo 10e. Street and Number 14235 Chadwick		Rockville	10f. Zip Code 20853			1		of What Country?
", or items aminer m	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	12. Was Decedent Ever		Was Decedent of If Yes, specify Cut			fy Yes or No- can, etc.)	14. F	Race - American Indian, Black, White, etc.
and Mental Hygiene. is marked other than "natural aumatic event, the Medical Ex	Completed by	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)		(Give	dent's Usual Occu kind of work done OO NOT use retired Caurant (during mo d)	st of working	7		f Business/Industry Service
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Health Sm 27 Sher tra		19a. Informant's Name/Relationship Debra Rochelle 20a. Method of Disposition	White -Daugh	ter 14325	Chadwic	k Lar		cville	, Mary	n, State, Zip Code) land 20853 on - City or Town, State
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ysician/ Medical caminer tamsit	cal Examiner	23a. Partif Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line. a. Septic Sharmon Due to (or as a constitution of the constitution). Acute Reservation Due to (or as a constitution). Acute Mye C. Due to (or as a constitution).	ock piritory pnsequence of): loid Leuk	Failure					Approximate Interval Between Onset and Deat
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nn 24 nours t he Funeral npletely fille	Medical	(Check 2 L Medical Exar	ysician: To the best of my miner: On the basis of exam irse Practitioner: To the be	nination and/or inves	stigation, in my opin	iion, death c	occurred at th	ie time, date a	nd place, and	due to the cause(s) and manner
_		29b. Signature and title of certifier	the_	_		se number	05		29d. Date sign	ned (Month, Day, Year) 2012
5		Nabila Khan, MD Date floor, 100 6 2012		st Glen F		er Sp	ring,	Mary1	and 20	910

DHMH 17 Rev 06-2011

		,	For State Registrar		State of	Marylar		artment of F		and Me		giene Reg. No. 20	112	17852
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1000	Medic Examir		4a. Facility Name (if not	institution, give s	treet and numbe			4b. City, Town, or		f Death	06 MD	4c. County	of Death	OMERY
	Funeral Director		5. Social Security Numb	9 1 -	7. M 2 X F	Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days		24 Hrs. 8	3. Date of Birt (Mo <i>nth, D</i> ay 9 –16–1	1		lace (State or Foreign
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Ba	permit. Page Department Important: I any injury o		21. Signature of Funeral	Service Licenses	Kurt E	31ake		Name and Addres				sky-Gold		and 20852
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ion of	4 Hospital or Attending Physician: The Is Luchours after death. Funeral Director: After this certificate he sted filled in by the funeral director, page		2 Accident	☐ Pending Investigation ☐ Could not be	28a. Date of in (Month, D	ijury Day, Year)	28b. Time of injury	28c. Injury work? M 1 🗆 Y	at	28d		w injury occurred		
Divis	tal or Airs after al Direct	Cerl	4 🗌 Homicide	determined	28e. Place of In building, 6	njury - At hor etc. <i>(Specify)</i>	me, farm, stre	et, factory, office		28f	Location (St City or Town	reet and Number , State)	r or Rural F	Route Number,
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			29b. Signature and title of	y L'n	95,	MD		29c. License	number	45E	3.	9d. Date signed	(Month, Da	ay, Year)
_	10		30. Name and address of PINKY	f person who con	mpleted cause of	death (Item	23a) (Type, Pr 22/8	int) CVISCO	NSIM	YAV	. St.	305	Be	ed. ay, Year) Hheoda MD 20814
	State Registra	e ir	31. Date GUNO 6	2012	32. Regist	trar's gignatu	park.	,						

are Goodman	ì	1- For State Registrar	ate of Maryland		artment of <i>rtificate of</i>		and	Menta	ΙНу		Reg. No	20		2	785
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edical Exam	inei	Primrose Clare 4a. Facility Name (if not institution				4b. City, To	wn orlo	ocation of F	_	May 27, 2	2012	c. County of	Death	2245	hrs
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Funeral		5. Social Security Number	6. Sex 7. Age	e (In yrs. I	last birthday)	If Under Months	1 Year Days	If Under 2 Hours		8. Date of B			9. Birt Foreig		ate or
Director		213-48-4102	1_M 2XF 6.	L .	Yrs	Yrs. Months Days Hours Min. 12-12-1950 Foreign Country							intry) E	ngland	
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212' ald be and Mental marke event	To Be	Herbert Steffe 19a. Informant's Name/Relationsh			19b. Mailing	Address				Ellio		ity or Town	State	Zin Code)	
MD 21215-0036 at 2 should be filed within 7 lith and Mental Hygiene. In 27 is marked other than aumatic event, the Medical	-	Keith Goodman	- Husband							ckvill					
		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from Sta		Place of Disposi crematory or oth		of ceme	tery,	[Date	20c.	Location - C	ity or 7	own, State	ө
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other tr		4 Donation 5 Other Spe	ecify:	Gan	rden Of										
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6876 ertificat ding ph	an/N	23b. Was decedent pregnant in the past 12 months?	I Live birdi		2 Fet	al death	3	Ectopic pre	gnanc	y	23	d. Date of de Month	elivery Da	зу	Year
Box 68760, death certificate be the attending physicist of for use as the burner of the street of th	Physician/N	1 Yes 2 No 9 Unkr	own 9 Unknown	ime of de	ath 5 Oth	er (Specify)								
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Division Bospital or Attence 4 hours after death Funeral Director:	Certification	3 Suicide 6 Could	ined (o r)	-		, factory, of	fice build	ding, etc.	- _		tate) 🗜	ayvie			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		4 Homicide 29a. Certifier 1 Certifying Phy	sician: To the best of my	lospi knowledg	_	ed at the tim	ne, date	and place,		altimo			stated	 đ.	
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Exam	iner:On the basis of exam and manner stated.			on, in my op	inion, de	eath occurre							
	Σ	29b. Signature and title of certifier	fico.				cense n				1	Date signed / 29, 2012		h, Day, Yea	ar)
4		30. Name and address of person w	the completed cause of de	ath (Item	23a)		IVI.	L ,		_	ivia	23, 201			
Ψ			ssistant Medical Ex	aminer	900 W. B	altimore	Street	, Baltimo	re, M	D 21223					
St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar	s Signatu	are										
ixegisi	Terr	JUN V V ZUIZ	LANGE P.												

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		1- For State Registrar					Certif	icate of	Dea	th				Reg. No		U I	2 110	0
Physici	an/	Decedent's Nan	ne (First, Midd	lle,Last)								2. Date of De	ath			3. Time of Death	_
dical Exami										Yea		2032 hrs						
		4a. Facility Name	4a. Facility Name (if not institution, give street and number)						b. City,	Town, or L	ocation of	Death	1	4c. County of Death				_
		502 Carroll	wood Roa	d					Midd	lle River					Baltimore	e Cou	nty	
Funeral		5. Social Security	Number	6. Sex	x	7. Age (Ir	n yrs. last l	birthday)	If Un	der 1 Year	If Under	24Hrs	8. Date of E	irth (MN	//DD/YYYY		hplace (State or	
Director		211_36_	2622	1 🕶	M 2 F	6	6	Vre	Mont	ths Days	Hours	Min	02/06	/19/	46	Foreig Col	n untry) Ilinois	c
		211-36-2622 1 M 2 F 66 Yrs. Workins Days Hours Will. 02/06/1946 Usual Residence of Decedent								+0	000	may, IIIIIOI	5					
k u k		10a. State	10b. County			100	c. City, To	wn or Location	n								10d. Inside City Limit	ts
	tor	M	D-1+	-i			Do 1+	imore									1 Yes 2 N	
Maryland 28a-f show d at once,		MD	Balt	Tinor	re		раті	TINOTE	400.7	0.4				10.0				
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ith the 23a or		502 Car:	rollwo	ood Rd. 21220						USA			A					
0036 within 72 hours after death with the Maryland jene. rer than "natural", ar items 23a or 28a-f sho. Medical Examiner must be notified at once.	Funeral	11. Marital Status			12. Was De Armed F		er in U.S.						pecify Yes or N Rican, etc.)	lo-	14. Race White		an Indian, Black,	
deat nr ite	'n	1 Never Marr	led 2 ∐.N	arried	1 Yes	2 x	No	" "	э, эрсс	ony ouban,	WICKICEIT, I	derio	rtican, etc./		VVIIILE	, 610.		
	by F	3 Widowed			If Yes, Give Ye or Dates:			1	Yes :	2 X No	specify:				Specify:	Whi	te	
2 hours afte "natural", Examiner	De.	15. Decedent's E	ducation (Spe	ecify onl	ly highest gra	de comple	ted) 16	a. Decedent		I Occupation				16b.	Kind of Bus	siness/Ir	ndustry	
72 h	Completed	Elementary/Sec	ondary (0-12)		College (1-4 or 5+)		during mo	St Of W	orking ine. L	001101	36 I G (I	ied)	So	cial S	Secu	rity	
Athin Athin	E	12				4	D:	isabil	ity	Exam	iner			Adı	minist	trat	ion	
Hygi		17. Father's Name	(First, Middle	, Last)						18	3.Mother's	Name	(First, Middle,	Maide	n Surname)			
21215-0036 vald be filed within 7 Mental Hygiene. marked other than	Be	Henry	J.	Go]							Nelli				Helle			
D 2. should and M. 7 is m.	2	19a. Informant's Na	ame/Relations	ship (Ty	pe, Print)			19b. Mailing	Addres	s (Street	and Numb	er or F	Rural Route Nu	ımber, (City or Town			
and 2 should sealth and Mc tem 27 is mater traumatic ever		Kimberle		olis	s (dau	ghter) I	Phoenix				5024	
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours afte ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.		20a. Method of Dis			Domoval 6	rom Ctoto		e of Disposit natory or other			etery,		Date	20c.	Location -	City or	Town, State	
MOFB Pages 1 nent of H net: If it		=	Other S	_	Removal ti	rom State					orn	06	/04/201	2 ,	Towsor	n 10	aryland	
Baltimore, permit. Pages la Department of He Important: It ite injury or ather to	4	21. Signature of Fu	ineral Service	Licens	ee Down	60	Dearr	01 122. Na	me an	d Address o	of Facility	nd:	a-Ruck	Fun	oral I	Home	of	_
Balt permit. Departi Import injury		V') R	_ (7	Denii.	13/6.	(all I						ındalk,				undalk, In	nc
Physician	_	23a. Part I. Enter ti	ne disease, o	compli	cations that o	aused the	death. Do										Approximate Interva	
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a Atherosclerotic Cardiovascular Disease											Between Onset and Death	d				
Examiner		Immediate Cause or condition resulti		_	ue to (or as a			culai Disc	asc									
		Sequentially list conditions, b																
	ē	if any, leading to in	nmediate		ue to (or as a	a conseque	ence of):						-			-		_
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O, e be e vsicia buria	/Medical		<u> </u>															
376 ficate g phy s the	ξ	IF FEMALE: 23b. Was decedent	pregnant in t	he	23c. If yes,		f pregnand	cy 2 Feta	المعاد الم	3 [Ectopic n	reana	nov.	23	3d. Date of o Month		Voor	
certi	Si.	past 12 months	5?		_	nant at time	of death				_Letopic p	Ji egi ia	ricy		WOTH	D	ay Year	
Box 687 ne death certifi. The attending hed for use as t	Physician	1 Yes 2	No 9 Un	known	9 Unkn	Unknown												
by th		Part II. Other sign	ficant condi	tions	contributing to	o death bu	t not result	ting in the un	derlyin	g cause giv	en in Part	I.	23e. Did	tobacco	use contrib	ute to th	ne cause of death?	_
cords, P.O. law requires that th has been signed by 2 should be detach	ğ												1 Ye	s 2	No 3	Proba	ably 4 🗹 Unknown	
ds, equir een s	Completed												24a. Was	an	24b. W	ere aut	opsy findings available	е
law r has b	힐												auto	psy om <u>ed</u> ?		ior to co	mpletion of cause of	
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tal Recition: The certificate ector, page	Be (25. Was case refer examiner?	red to medica							26.Place o		heck o	only one)					
ith single in the state of the	2	1 ✓ Yes	2 No	HC	ospital: 1	Inpatient	2 ER	/Outpatient	3 🔲 I	DOA O	ther4 🔲 N	Nursin	g Home 5	Reside	ence 6 🗸	Other:	Scene	
ling Ph After t funeral	on:	27. Manner of Dear			28a. Date (Month	of Injury n, Day,Year)	28	b. Time of Inj	ury	28c. Injury			28d. Describe	how inj	ury occurre	d		
ion feath. tor:	ä	2 Accident	5 Pen	ding stigation	,					1 Ye	s 2 N	ю						
ViS or A or A or A Direction by	rtificati	3 Suicide	. \square	ld not be	28e Plac	e of Injury	- At home,	, farm, street	factor	y, office bui	lding, etc.				and Number	or Rur	al Route Number, City	/
Company Comp																		
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									t the time, date	and pl	ace, and du	e to the	cause(s)					
FSFS	ž	29b. Signature and	title of certific						29	c. License r	number			29d.	Date signed	d (Mont	h, Day, Year)	٦
		5. Di),							O.C.M	.E.			Jun	ne 1, 201	2		
	ł	30. Name and addr	ess of person	who co	mpleted caus	se of death	(Item 23a	1)										\dashv
5		Donna M. V			Assistant N	/ledical l	Examine	er 900 V	V. Ba	ltimore S	Street, B	altim	ore, MD 2	1223				
St	ate	31. Date filed/Mon	b Day Year)	10	32. Re	egistrar's S	igrature	back	,									\dashv
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 3, Lance Gilman June 2:13 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 971 Redfield Road Apt. D Bel Air Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral Director** 230-56-0270 1 ★ M 2 □ F 66 11/17/1945 CA Usual Residence of Decede or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Harford Bel Air 1 🗆 Yes 2 🎦 No 10e. Street and Number 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? Funeral 971 Redfield Road, Apt. D 21014 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 KNo Specify: Specify. 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Sales Associate Department Store Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Gilman Jean Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Garrett Gilman - Son 2941 Corte Diana, Carlsbad, CA 92009 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or Atlantic Crematory 06/06/2012 Glen Burnie, MD Si ature of Fineral Sirvice License Schimunek Funeral Home 22. Name and Address of Facility any 610 W. MacPhail Rd., Bel Air, MD 21014 1 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part 1. Enter the dis shock, or heart failed Approximate Interval Between Immediate Cause (Final ierato allular Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Physician/Medical Examiner If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has page 2 autopsy perform death? 2 Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita 1 Yes Other: ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 No Accident Investigation 24 hours after death Funeral Director, Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 1019 115CL 79 6-5-2012 2021 15 Emmorton Rol Sult 210, Bel AIR MP 21015

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#18perFH, G928, 671572012, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 06 2012 Robert Lee Ghormley, Jr. 11:45 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5408 Christy Drive Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country D.C. 1 X M 2 □ F 579-52-7570 (Month/29/1923 88 Director Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Bethesda 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5408 Christy Drive 20816 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 1

If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates. U.S. Nouv White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Armed Forces Federal Government Be 18. Mother's Name (First, Middle, Meiden Sumame)

Lucille Elizabeth Lyon
Namey Stanley 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o မ Robert Lee Ghormley 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Ghormley Lamb / Daughter 5704 Beech Ave., Bethesda, MD 20817 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 6/7/2012 Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ T cell lymphoma disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) death certificate be executed Cause (Disease or linjury nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atter for u 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Atrial Fibrillation Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of Hospital or Attending Physician: The law cate has page 2 s autopsy performe death? this certificate 2 X No 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at After 28d. Describe how injury occurred 1 Natural 5 Pending injury thin 24 hours after death.

the Funeral Director: Af
mpleted filled in by the fu 1 Yes Accident Investigation Could not be 2 No Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Within 2 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 37142 June 4, 2012 Ox's 30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print) G. Coleman 6001 Muncaster Mill Road, Rockville, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Division of Vital

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ^{Day}2012 Cassia Hayes 24. 0005 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 263-04-4307 **Director** 1 □ M 2 🗶 F 59 Dec. 10, 1952 Florida Usual Residence of Deced permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar most of the process. 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Prince George MD 1 Yes 2X No Fort Washington 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 8726 Cumbria Court 20744 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify Specify: Black Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Security Officer Military Base Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ George Cummings Mary Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Weems - Daughter 400 Flormond Avenue, Ormond Beach, FL 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗌 Cremation 3 🗆 Removal from State Sunset Park Cemetery 06-09-2012 | Daytona Beach, FL 4 ☐ Qonation 5 ☐ Other (Specify) 21. Si nat re of Funeral Service Licensee Metropolitan Funeral Service 22. Name and Address of Facility 20 5517 Vine Street, Alexandria, VA Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ encephalo path disease or condition resulting in death) HOOXIC Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury or as a considering of henodialysis Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. tnd stage On renal disease burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) jo in the past 12 months? Month Pregnant at time of death Day Year be detached g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed 1 🗌 Yes 2 🗌 No 1 Yes 2 No filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 100 Other: 2 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 - Natural 5 Pending work? 1 ☐ Yes 2 ☐ No after death. M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 24 hours a Funeral I Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) D68005 mp 20 orindi 24th 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) QV Jennifo Obigdi, mp 7600 Carroll Avenue Takoma Park, MD 20912 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			101	laryland				l Mental Hyo	giene				
			State Registrar		Cer	tificate of D	- 1	Reg. No. 20 2 1785					
	Physicia		Decedent's Name (First, Middle, Last) BETTY ALENE LANIER HAI	ER HARRIS					5, Day 2012 Year	3. Time of Death 3:36 AM			
	Medic Examir		4a. Facility Name (if not institution, give street and number)			4b. City, Town, or L	Location of Dea	June ath	4c. County of De				
			12139 Dove Circle			Laure	1		Prince	e George's			
	Funeral			ge (In yrs. last	t birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir			Birthplace (State or Foreign Country)			
	Director		259-50-4299 Usual Residence of Decedent	77	Yrs.			Aug. 4,	, 1934 G	eorgia			
	and shov	힏	10a. State 10b. County	10c. City, 7	Town or Loc	ation				10d. Inside City Limits			
	Mary 28a-f otifie	irec	GA Bulloch	Stat	tesboı	0				1 Yes 2xxNo			
	h the	a D	10e. Street and Number			10f. Zip Code			10g. Citizen of What (Country?			
	ms 2; must	Funeral Director	391 Aikens Pond Road	F	40.14	30463		0 " W N	U.S.A. 14. Race - American Indian.				
(O	within 72 hours after death with the Maryland jiene. If than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Ft	11. Marital Status 12. Was Decedent Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2X2	•	13. V	as Decedent of His Yes, specify Cuban	, Mexican, Pue	erto Rican, etc.)	14. Race - An Black, Wh				
21215-0036	rs aftural",	edk	3 XXWidowed 4 ☐ Divorced If Yes, Give Year or Dates.		1	Yes 2 XX	Specify:		Specify: W	nite			
5-0	2 hou "natu edical	Completed	15. Decedent's Education (Specify only highest grade completed)		16a. Deced	ent's Usual Occupat	tion	orkina	16b. Kind of Business/Industry				
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d 2	£ \$ £ £	Be (17. Father's Name (First, Middle, Last)		HOME		18 Mother's N	ame (First, Middle, I	Own Home				
Maryland	should be file and Mental F	မ	James Lanier				Hattie		vialderi Gurriarrie)				
ary	of Health and Ments of Health and Ments fitem 27 is marked rother traumatic e		19a. Informant's Name/Relationship (Type, Print)	- 1	19b. Mailin	g Address (Street an	nd Number or F	Rural Route Number,	; City or Town, State, 2	Zip Code)			
	ealth n 27 ner tra		Jeffery L. Harris / son		12139	Dove Ci	rcle L	aurel, Ma	ryland 2	0708			
ore	Page 1 al nent of H ant: If itel ury or oth		20a. Method of Disposition 1 □ Burial 2 ※X gremation 3 □ Removal from State	cem	netery, crem	ition (Name of atory or other place)		Date	20c. Location - City	or Town, State			
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			23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lin	est,	Approximate Interval Between								
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Box (ath ce attend for us		23b. Was decedent pregnant in the past 12 months? 1 Live Birth 2 Pregnant 2 Pregnant 2	2 Fetal d	leath 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of d Month	delivery Day Year			
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ital	siciar certif irecto	Be c	25. Was case referred to medical examiner? 1 Yes 2 XXo Hospital:			Othor	ce of Death (Ch			Sons			
of V	y Physer this eral d	e: To	27. Manner of Death 28a Date of init	ient 2 ER ıry 28	3b. Time of	3 L DCA 28c. Injury a	4 L Nursing		ence 6 X Other (Spe ow injury occurred	ecify) Residence			
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of a contract of the basis of the contract of the basis of the contract of the basis of the bas	examination ar	nd/or investig	gation, in my opinion,	death occurred	d at the time, date an	nd place, and due to the	cause(s) and manner stated.			
	Vithin Fo the compl	Σ	only one) 3 Contifying Nurse Practitioner: To the 29b. Signature and the of certifier	e best or my r	knowleage, (29c. License r			e cause(s) and manner 29d. Date signed (Mor				
			1 Xummel Co	men	house	D001	7135		June 5,				
	a.1		30. Name and address of person who completed cause of c			int)							
	8 V		11111	50 Kno ar's Signature		rth Drive	Colum	mbia, Mar	yland 210	45			
State Registrar		e ar	31. Date filed (Month, Day, Year) JUN 0 6 2012 32. legistr	a s dignature	. 190	West							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Suzanne E. Herbert Month 25 807 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Largo Prince Georges 10500 Louisville Lane If Under 1 Year If Under 24 Hrs. 6. Sex last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) ct 4, 1963 220-82-6065 1 □ M 2 🗓 48 Months Days Hours Min Wash D.C. Director Oct Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director MD Prince Georges Largo 1 ¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? items 23a Funeral 10500 Louisville Lane 20774 U.S.A. death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc 1 Never Married 2 Married "natural", or by Yes 2 X No Baltimore, Maryland 21215-0036 72 hours after Specify: Black 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 X Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) Gollege (1-4 or 5+) Disabled Private Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If Item 27 is marked o any injury or other traumatic eve any injury or other traumatic eve ည Marian Poole John Waller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 404 Green Street Laurel, MD 20724 Andrew Webster/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Riverdale Crematory June 5, 2012 Riverdale, MD J.B. Jenkins Funeral Home, Inc. 21. Signature of Funeral Service Licen 22. Name and Address of Facility 7474 Landover Rd Hyattsville, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ uncontrolle disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last burial-trar attending physician and Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed this certificate 2 🗌 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred injurv 5 Pending Natural 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my spirit 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who co

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

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pleted cause of death (Item 23a) (Type, Print)

Registrar's Signature

		-	State Amend Item	State of Ma 24a per ve	aryland e rb., g	/ Depa 928_0	rtment of 106 120	f Health 12dhh Deair	and M	1ental H	ygien Reg. N	e 20	12	17	860
			Decedent's Name (First, Middle, Las		2. Date of Death 3. Time of D					f Death					
	Physicia /Medic	_	Mildred D. Holzs		May 12, 2012 Year 10:30 A					MA C					
100	Examin		4a. Facility Name (If not institution, give	4b. City, Town, or Location of Death				4	c. County of						
-			Oakcrest Village					Imore	-04 []			Balt:			
	Funeral Director		220-14-4117	ex 7.Ag □M2XTF	ge (In yrs. la.	st birthday) Yrs.	If Under 1 Ye Months Da		Min.	8. Date of (Month, Apr 8	Day, Yea, 192	r) 25	Coun	ace (State try) Land	or Foreign
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation						10	d. Inside C	City Limits
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	r 28a	Director	10e. Street and Number	1.6		Jar Crin	10f. Zip Cod	de			10g. C	citizen of Wh	nat Coun	try?	
	h with		8800 Walther B1	vd #2211				21234	•			USA	A		
	ems sr mm	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	. 13. V	Vas Decedent Yes, specify C	of Hispanic C	rigin? (Sp	ecify Yes or	No-	14. Race	- America		
36	or it	by Fu	1 Never Married 2 Married	1 ∐Yes 2 ሺ lf Yes, Give	No	1	□Yes 27					Specify:		ite	
ö	hours tural"	q p	3 ¼ Widowed 4 □ Divorced Year or Dates:												
7 21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) (Give kind of work done during most of working life. DO NOT use retired)							111000/1110	ustry				
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Z Nar	2 s n ar rsu		19a. Informant's Name/Relationship (Patrick Troy/son	Type. Print)			g Address (Str Middle							Code)	
ටට S Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other t		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4X Donation 5 ☐ Other (Specification)		20b. Pla	ace of Dispos metery, cren	sition (Name of natory or other	f place)		Date	20c.	Location - C	City or To	wn, State	
Balt	permit. Depart Import any inj once.		21. Signature Funeral Service Licensee Are Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201										t		
<i>C</i> , I			23a. Part 1. Inter the disease, or com shock, art failure. List only	olications that cause	d the death.						y arrest,			Approxima Interval Be	ite etween
	Physician		Immediate Cause (Final disease or condition	_	Suda	len	death) ^						Onset and	Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):												
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	uted d ansit	Examiner	d any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
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4	cate be executed physician and the burial-transit	lical		d											
-0 0		Med	IF FEMALE;												
O. Box	The law requires that the death certific ate has been signed by the attending p age 2 should be detached for use as	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown									Date of delivery Month Day Year			
بر م	w requires that the d s been signed by the should be detached	by Pr	Part II. Other significant conditions	ontributing to death t	out not resul	ting in the ur	nderlying cause	e given in Part I. 23e. Did tobacco use contribute to the cause of death?							death?
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SS		Com								ı p. 1 □ Ye	utopsy erformed s 2 2	? do	eath? □Yes		04430 01
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3 5	ys dir is	ဥ	1 ☐ Yes 2 No				t 3 DOA		Nursing H	ome 5				y)	
4 io	ding l h. After funer	tion	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inj (Month, Da	ay, Year)	28b. Time of Injury		Injury at Work? 1 □ Yes 2 [¬No	28d. Descri	be now in	ijury occurre	ed		
2:0	Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certific tely filled in by the funeral director, i	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined		jury - At hor	ne, farm, str				28f. Locatio	n (Street	and Numbe ate)	r or Rura	l Route Nu	mber,
Divi	tal or rs afte al Dir led in	Cert													
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Z	To th Within	Me	29b. Signature and title of certifier	<u> </u>			29c. Lie	cense numbe	-		29d.	Date signed	(Month,	Day, Year)	
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240	0.0		30. Name and address of person who	completed ause of	death (Item	23a) (Type,	Print) WM	ther	BN	a Pa	aki	ille	mī) 21	234
71	Sta	_	31. Date filed (Moath, Day, Year)	4	rar's Signati										
	Registr	ar	2012	Trem.	de 1	. 23									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 545 PM Alesia Lynette Hart Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Doctors Hospital Prince Georges Lanham Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral Director** 123-50-2815 1 M 2 XF 50 Yrs Dec 13,1961 Usual Residence of Decede or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Prince Georges Upper Marlboro 10e. Street and Numbe 10g. Citizen of What Country? items 23a or ner must be r Funeral 16601 Pleasant Colony Drive 20774 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten edical Examiner r 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: Black Completed 3 🗌 Widowed 4 💢 Divorced and 2 should be filed within 72 houn Health and Mental Hygiene. tem 27 is marked other than "natui other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) <u>Administer</u> Government Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Alphonza Hart Verneice Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traconce. Gwendolyn Bardwell/Sister 16601 Pleasant Colony Drive Upper Marlboro, MD 20774 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ressurection Cemetary June 6,2012 Clinton, Maryland Signature of Funeral Service License J.B. Jenkins Funeral Home Inc. 22. Name and Address of Facility 7474 Landover Rd Hyattsville, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** epsis Sequentially list conditions, Examine Dusito (or se a noneccuanna di) cause. Enter Underlying Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Pregnant at time of death 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops After this certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work?
1 Yes 2 No Accident Suicide after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie D63631 sslaw 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Luck Rd., Lanham, Md 20706 8118 GOOD Bishaw 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 24a,25,26,27,29a per dr., g928,07,06/2012dhb trar Certificate of Death Reg. No. For A State A Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 830 PM Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltmore Baltmors Nursin If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🚨 Months Days Hours (Month, Day, Year) Director Maryland Usual Residence of Decedent 28a-f shov 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1

Yes 2 □ No Baltimroe MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21225 707 E. Patapsco Avenue death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11, Marital Status 14. Race - American Indian. Armed Forces?

1 XYes 2 No Black, White, etc. þ 1 X Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Exami Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) roofer homw improvement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Deaulah Bocco Samuel Andrew Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 707 E. Patapsco Avenue Baltimore, MD Linfa Hannigan/caregiver 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1
Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 X Other (Specify) Signatur of Euneral Survice State Anatomy Board 655 W. Baltimore Street enn MD 2120 Baltimore. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Dementig disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Dixias Sequentially list conditions, Examine fran, leading to immediat cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Records, P.O. Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Yes 2 No ed by the a detached f 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t 23e, Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy funeral director, page 2 performed? death? 1 ☐ Yes 2 X No certificate 25. Was case referred to medical examiner?

1 □ Yes 2 ☒ No Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28c. Injury at work? 1 🗌 Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: injury X Natural 5 Pending 2 🗆 No death. Accident after death Investigation the 6 Could not be Sulcide within 24 hours after de
To the Funeral Directo
completed filled in by th 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie ပ M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N Euton Street July 308 Balhmremp BUUTAN 31. Date filed (Month, Day, Year, 62. Registrar's Signature State JUN 0 6 2012 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ ANNE N. HELLMANN 11:15 AM^M JUNE 2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE COUNTY KINGSVILLE 7511 DAYS WOODS COURT 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 24 Hrs. Hours Min. . Age (In vrs. last birthday) **Funeral** Months 218-68-5479 52 Director 10-19-1959 MARYLAND 28a-f show 10d. Inside City Limits 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 X No KINGSVILLE MD. BALTO. 10g. Citizen of What Country? 10e. Street and Number Funeral Page 1 and 2 should be filed within 72 hours after death with : ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a 7511 DAYS WOODS COURT 21087 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces Black, White, et 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. ģ 1 ☐ Yes 2 No Specify WHITE Baltimore, Maryland 21215-0036 3 Divorced Completed item 27 is marked other than "nature other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) REGISTERED NURSE HEALTHCARE Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ JUANITA CLARK HOWARD NORMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7511 DAYS WOODS COURT KINGSVILLE, MD. 21087 STEVEN M. HELLMANN SPOUSE 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o once. 1 Burial 2 K Cremation 3 Removal from State ATLANTIC CREMATORY 6-6-2012 GLEN BURNIE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. Signature of Funeral Service Licenses 9705 BELAIR ROAD NOTTINGHAM, MARYLAND 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final metastatic Colon ca Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence of and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Control of the contro in the past 12 months? Month Day Year Pregnant at time of death detached 1 ☐ Yes 2 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy autopsy performed? Vac 21 No 1 Yes 1 Tes To Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation within 24 hours after death

To the Funeral Director: /
completely filled in by the 1 Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United States of the Cause of t only one) 29b. Signature and title of certifier 153070

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Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day,

JUN 0 6 2012

Olkans St Roon 4mu9 Balkmox, MD 21287

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 29 2042 Physician/ Month Michael D. Hipchen 2:37 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore County Towson Gilchrist Hospice If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 218-68-7154 1 🛂 M 2 🗆 F **Director** 09/27/1955 MD 56 Usual Residence of Decede "natural", or items 23a or 28a-f show dical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State with the Maryland Director Bel Air 1 Yes 2 No MD Harford De. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21015 USA 1429 Redfield Road within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc δ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White Specify. 3 - Widowed 4 - Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Siemens MRD Solutions traumatic event, the Medical Service Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Dorothy Flury Gerard Hipchen permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1429 Redfield Rd., Bel Air, MD 21015 Deborah Hipchen - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place Gardens of Faith 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 06/04/2012 Baltimore, MD 22. Name and Address of Facility anature of Funeral Service Licenses Schimunek Funeral Home aé 610 W. MacPhail Rd., Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Amotraphic Physician/ disease or condition resulting in death) 1-cars Medical Examiner Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury sician and burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death ed by the a Unknown g 🗌 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown been signated l Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed Yes 2 certificate 2 XNo 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ER/Outpatient 3 DOA 1 🗌 Inpatient 2 🗌 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after deau.

To the Funeral Director: After t 1/1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check onty one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)

Registrar

State

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N. Charles

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | 2

State Registrar Certificate of Death 2. Date of Death Physician/ you. 257 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Season's Hospice Randallstown Baltimore Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Michigan X M 2 D F Months Days Min M877/28/1951 **Director** 367-52-4373 60 Vrs 28a-f show 10a. State 10c. City, Town or Location the Manyland must be notified at 10d. Inside City Limits Director Y Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 23a 6708 Beech Avenue 21206 **USA** "natural", or items Page 1 and 2 should be filed within 72 hours after death \u00e4ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 💥 No Specify Completed 3 Widowed 4 Divorced Specify Year or Dates. 1971-1975 White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Highway Supervisor State Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Robert Hansen Luella Egbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Hansen / Wife 6708 Beech Avenue, Baltimore, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☐ Burial X☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 6/6/2012 Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death DDER Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): burial-tra Due to (or as a consequence of): resulting in death) Last physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the box Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed Yes death?
1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 **O** No 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Natural 5 Pending injury 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 30. Name and address of person who complete d cause of death (Item 23a) (Type, Print) Arc 31. Date filed (Month, Day, Year) State **JUN 0 6** Registrar

Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

	Registrar 1. Decedent's Name (F				Certificate of	Death		2. Date of Dear		116	3. Time of Dea
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er	4a. Facility Name (if not	t institution, give stre 10605 Hickor		ne	4b. City, Town		of Death ambia		4c. Coun	ty of Death H o	oward
	5. Social Security Number 503-24-60 Usual Residence of D	03 1 🗆	7. Age	e (In yrs. last birtho 86 Yr	Months Day		Min.	8. Date of Birth (Month, Day Apr 2			hplace (State or Fo untry) SD
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Funeral Di	10e. Street and Numbe 10605 Hicko	ry Crest Lan	ie		10f. Zip Code		044		10g. Citizen o	f What Cou	
þ	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 ☐	2 Married	2. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	13. Was Decedent of If Yes, specify Cu	uban, Mexica	n, Puerto	cify Yes or No- Rican, etc.)		ack, White	ican Indian, , etc. hite	
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	19a. Informant's Name Jackie Hart	e/Relationship (Type, tzler Daugh			Mailing Address (Stree 0605 Hickory					State, Zip	Code)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ Florence Anna Herrick 11:30 P M June 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Encore at Turf Valley Ellicott City Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
June 15,1919 Social Security Number Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday, Days Director 215**-09-**5587 1 M 2 X F 92 New Jersey Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director or 28a-f sl MD Howard 1 Yes 2 X No Ellicott City ō 10e. Street and Number 10g. Citizen of What Country? ns 23a r must b be Funeral 11150 Resort Road Apt 303 21042 USA "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Completed by 1 Never Married 2 Married 1 Yes 2 2 🔀 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 🛮 Widowed 4 🗌 Divorced Year or Dates 1 and 2 should be filed within 72 hour of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John DeBoer Katherine DeNucci 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnn Klatt Daughter 5999 Calvert Way; Eldersburg, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State New Cathedral Cemetery 6-6-2012 4 Donation 5 Other (Specify) |Baltimore, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. Signature of Funeral Service Licensee 630 Edmondson Avenue; Catonsville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Disease or injury Due to (or as a consequence of): the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 be detached signed by page 2 should this certificate has

Physician/Medical Be Completed by 뎯 Certificate: Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who c

Andrew Lazris

JUN 0 6 2012

art II. Other significant conditions co	ontributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tobacco use contribute to the o		
			24a. Was an autopsy prior to comp performed? 1 ☐ Yes 2 【█ No 1 ☐ Yes 2	letion of cause of	
5. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	26. Place of Death (Che		ssisted Living	
7. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation			28d. Describe how injury occurred		
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
(Check 2 Medical Examin	ner: On the basis of examination and/or inv	estigation, in my opinion, death occurred	and due to the cause(s) and manner as stated. at the time, date and place, and due to the cause place, and due to the cause(s) and manner as stat	(s) and manner stat	

29c. License number

D47447

6334 Cedar Lane #103; Columbia, MD 21044

29d. Date signed (Month, Day, Year)

June 4, 2012

Registrar DHMH 17 Rev 06-2011

8

State

within 24 hours after death.

To the Funeral Director: After filled in by

or death (Item 23a) (Type, Print)

mpleted co

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ George Everhart Irwin, II May 23 2012 23:55 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7070 Cradle Rock Way Apt 119 Columbia Howard 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1**X** M 2 □ F Months Hours 12^{(M}9ⁿ5, Diy9^y32 **Director** 579-42-9888 79 Pennsylvania Usual Residence of Decedent or 28a-f show notified at 10a. State filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Howard Columbia 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code rral", or items 23a or Examiner must be 10g. Citizen of What Country? Funeral 7070 Cradle Rock Way Apt 119 21045 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1

Yes 2 □ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes Give "natural" Completed 3 Widowed 4 N Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the 12 Printer Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filk tment of Health and Mental I tant: If item 27 is marked o nd Mental I ပ George Everhart Irwin, Sr. Sara Fegan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa Fischer (Daughter) 3200 Brighton Court Woodbine, Maryland 21797 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Culpeper National Cem 6-7-2012 Culpeper, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Witzke Funeral Homes, Inc. Mo123 5555 Twin Knolls Road Columbia, MD 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ DEBILIT disease or condition resulting in death) Medical Examiner DOGV Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying signed by the attending physician and d be detached for use as the burial-transi Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA eral Director: After this filled in by the funeral di 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending Accident Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral C

completed filled Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title o 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO 30O

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month,

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			For State	State of Marylan		artment of l <i>rtificate of l</i>		and Mer		0.0	112 1786	C
			Registrar 1. Decedent's Name (First, Middle, Last)		00	rincate or i	Death		Date of Deat		3. Time of Death	_
	Physicia Medic		PRISCILLA I		JAM	ies_			Month プロリモ_	Day	2012 01:234 M	1
	Examin		4a. Facility Name (if not institution, give str BALTIMORE WASHINGT	ON MEDICAL	CENTE		LEN 1	BURNIE		4c. County	ARUNDEL	
	Funeral Director		235-38-0095	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours		Date of Birth (Month, Day, BD • 7	^Y °1′926	9. Birthplace (State or Foreign West ^(y) Virginia	
	and show at		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation		-			10d. Inside City Limits	3
	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	Director	Maryland Anne Art	ındel Han	over						1 ☐ Yes 2 🔼 N	0
	th the		10e. Street and Number			10f. Zip Code 21076			1	0	What Country?	
	ems 2	Funeral	19 Leeds Road 11. Marital Status	2. Was Decedent Ever in U.	S. 13.	Was Decedent of I	Hispanic Ori	gin? (Specify	Yes or No-		se - American Indian,	_
စ္က	fter de , or ita amine	þ	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give		If Yes, specify Cub 1 ☐ Yes 2 M No			ın, etc.)	Blad	ck, White, etc.	
8	ours af tural"	sted	3 Nidowed 4 Divorced	Year or Dates.						Specify	wille	_
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	within /giene.		Elementary/Seconday (0-12)	N/A	Ac	ecounting	Cler	k		Westin	ghouse	_
and	be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last)	December 1					rst, Middle, N	faiden Surnam Cook	e)	
Maryland	should b and Mer is mark raumatic	Ė	Enis John 19a. Informant's Name/Relationship (Type	Evans e. Print)	19b Maili	ina Address (Street	Dais		ute Number	-	State, Zip Code)	
	t. Page 1 and 2 tment of Health rtant: If item 27 njury or other t		Kelly M. Brannon (Daughter)	1	ennessee						
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ R		Place of Disponentery, cre	osition (Name of matory or other pla	ice)	Date		20c. Location	- City or Town, State	
ţ			4 Donation 5 Other (Specify)	At]		Crematic					rnie, Maryland	_
Ba	permir Depar Impor any ir		21. Signature of Funeral Service Licensee	MOD-732		McCully-F	olyni Naja	ak Fun	eral H	Home, P	.A. yland 21122	
NJ.	h_sician/ Medical Examiner	er.	23a. Per 1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	cause on each line. hypotheria fen. Due to (or as a conseq	th. Do not ent	ter the mode of dyi	ng, such as	cardiac or res	spiratory arre	st,	Approximate Interval Between Onset and Death	
092	cate be executed physician and s the burial-transit	ledical Examiner	If any heading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d.									
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death certificate has been signed by the attending physici To the Funeral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	ic. If yes, outcome of pregna 1 Live Birth 2 Fet 4 Pregnant at time of g Unknown	al death 3	☐ Ectopic pregnar☐ Other (specify) _	ncy				23d. Date of delivery Month Day Year	
ls, P.O.	requires that the death been signed by the atte should be detached for	ed by P	Part II. Other significant conditions conditions	tributing to death but not res LINAL OU LARCE'NOME	sulting in the	underlying cause g	iven in Part	I.		_	acco use contribute to the cause of death?	
Division of Vital Records,	The law requarte has been bage 2 shou	omplete	Renal cire	wunom	٤.				24a. Was ar autops perforr	med?	Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No	,
tall	cian: ertifica ector, I	Be	25. Was case referred to medical examiner?	ospital:				ath (Check onl	y one)			
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o uc	nding ath. r: After e fune	icate	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year)	injury	wor		.	. Describe no	w many occur		
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	he Hospita in 24 hours he Funeral pleted filled	Medical	(Check 2 Medical Examine	ian: To the best of my know r: On the basis of examination Practioner: To the best of m	on and/or inve	stigation, in my opin	ion, death o	ccurred at the	time, date an	d place, and du	ie to the cause(s) and manner sta	tec
	To the within 70 the comple		29b. Signature and title of certifier	^		29c. Licens		. /	2		ed (Month, Day, Year)	
	1		30. Name and address of person who cor		n 23e) /T		6519			06/0	1/2012	
	[O √	0	30. Name and address of person who con SHIMEY SAM 31. Date filed (Month, Day, Year)	301 HOSPI 32. Registrar's Signa		DRIVE	90	EN B	BURN.	ME 1	MD-21061	_
	Sta Registr		JUN 0 6 2012		back							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Jr. Jubb, Gerald Thomas 02 0734AM 2012 TUNE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** AGNES HOSP N/A BALTI Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth Social Security Number If Under 24 Hrs. **Funeral** Months Hours (Month, Day, Year) 217-54-0559 **Director** 1 🙀 M 2 🗆 F 62 July 21,1949 Maryland show 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director Selbyville 1 Yes 2 X No Sussex DE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with 38774 Wilson Avenue 19975 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 🔀 Married 1 X Yes 2 ☐ No If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 🗌 Widowed 4 🗌 Divorced Year or Dates marked other than "natur matic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years College (1-4 or 5+) and Mental Hygiene. General Motors Corp. Auto Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Sarah F. Brune Gerald T. Jubb, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38774 Wilson Ave. Selbyville, DE 19975 19a. Informant's Name/Relationship (Type, Print) .0 Mrs. Elizabeth M. Jubb(Wife) item 27 i 20b. Place of Disposition (Name of cemetery crematory or other place)
Hillyop Service Corp 6/8/2012 20a, Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ot 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland marles Si ature Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk. Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ TUMOR LYSIS SYNDROME UNKNOWN disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner B-CELL LYMPHONA UNKNOWN FOLLICULAR RECURRENT Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death signed by the a Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To the Hospital or Attending Physician: The law requires a within 24 hours after death.

To the Funeral Director After this certificate has been sign completely filled in by the funeral director, page 2 should be LOW PLATELETS, CHEMOTHERAPY, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Records, Completed VIRAL 24a. Was an 24b. Were autopsy findings available ESOPHAGITIS RADIOTHERAF CANDIDAL autopsy performe prior to completion of death? METASTASIS YMPHOMA Yes of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 \square Pending injury Natural
Accident Division 1 Yes 2 No Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗖 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2012 24433 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CATON AVE. BALTIMORE, MARUPUDI. 900

Registrar

DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 20 Î 2 JUNE EDITH JOHNSON 5:00 A M PAULINE Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MONTGOMERY SPRINGBROOK CENTER SILVER SPRING Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Director 1 M 2 X F 76 410-56-1732 FEB. 4 1936 TENNESSEE 28a-f show 10h County 10c. City, Town or Location 10d Inside City Limits or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director Yes 2 No SEAT PLEASANT PRINCE GEORGE'S 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 7200 JOPLINE STREET 20743 USA death Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11 Marital Status Armed Forces?
1 ☐ Yes 2 🔼 No Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 hours after BLACK 1 Yes 24 No Specify If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry Je filed with... *al Hygiene. `≈r than "r (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12TH GOVERNMENT CORRECTION OFFICER and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Ρ. FANNTE GEORGE DAVIS TUCKER ALICE injury or other traumatic permit. Page 1 and 2 should the Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3366 CANTON COURT DUMFRIES, VIRGINIA LINDA TUCKER/DTG. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State MD VETERANS CEMETERY 6/7/2012 4 Donation 5 Other (Specify) CHELTENHAM, MARYLAND 21. Sign vure of Faveral Ser 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. e Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ACUTE CARIORESPIRATORY FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner CHRONIC HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury FAILURE TO THRIVE burial-tran that initiated events P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be execumithin 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician an Due to (or as a consequence of): resulting in death) Last Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Dav Year 5 Other (specify) Pregnant at time of death signed by the a 1 ☐ Yes 24 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown been sig 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy nerform death? 1 Yes 2X No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Yes 2 🎦 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1¥ Natural 5 Pending injury Accident Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifle 29c. License number 29d. Date signed (Month, Day, Year) D63232 JUNE 5, 2012

P

State Registrar 15245 SHADY GROVE ROAD SUITE 130 ROCKVILLE, MARYLAND 20850
31. Date filed (Month, Day, Year)

JUN 0 6 2012

34. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PATRICIA GOMEZ M.D.

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Exami

Be Completed by Physician/Medical

Medical Certification: To

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show eny Injury or other traumatic event, Ite Modical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

physician and s the burial-trans attending p signed by the a d be detached for certificate has been s rector, page 2 should funeral director, After iours after death.

neral Director: A
filled in by the fu 24 hours a within 24 hor To the Fune completely fi

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

23b. Was decedent pregnant in the past 12 months? 1 □ Yes ∠ , No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
Part II. Other significant condition	s contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
Ischemic	Curciomyo pathy	1 No 3 Probably 4 Unknown
	Prostate Concer Obstructive Purmnary Disease	24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No
25. Was case referred to medical		th (Check only one)
examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing H	ome 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ★Natural 5 Pending 2 Accident investiga	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		28f. Location (Street and Number or Rural Route Number, City or Town, State)
	Physiclan: To the best of my knowledge, death occurred at the time, date and place xaminer: On the basis of examination and/or investigation, in my opinion, death occu and manner stated.	

29c. License number

DOU 47223

5218

29d. Date signed (Month, Day, Year) 05/30/2012

Baltimore mo

State Registrar

DHMH 17 Rev 1/2001

0

Karen M. Lynn Piper mio

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ HORACE LEE JAMES 2012 JUN 10:50 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WALTER REED NATIONAL MEDICAL CENTER MONTGOMERY BETHESDA 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 8 Date of Birth 9. Birthplace (State or Foreign 1X M 2 □ F Months Days Hours Min 0271371944 Director 423-52-7301 68 Alabama Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 XYes 2 No MD Prince George's Upper Marlboro 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4205 Canyonview 20772 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Armed Forces?

1X Yes 2 No.4-1991

Year or Dates. Black, White, etc. þ 1 Never Married 2X Married 1 ☐ Yes 2X No Specify. Specify: Black 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Aircraft Technician years US Air Force Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Robert Lee James Mable Washington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Sonja James/Daughter 14523 Marlborough Circle Upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery | 06/11/2012 | Cheltenham, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Nuan Marshall-March Funeral Home 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ HEPATOCELLULAR CARCINOMA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) burial-Medical death certificate be the. attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Pregnant at time of death Month 9 Unknown 9 Unknown that the by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 24 hours after death. Funeral Director: After this certificate has been sign Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy page perform 2 **X**No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 **X**Vo 1 Yes Other: ဂ္ 1 X Inpatient 2 ER/Outpatient 3 E 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Defining rijectari. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat ure and title of certifie 29d. Date signed (Month. Day, Year) VA 0101251302 JUN 4 2012 30. Name and address of person who completed cause of death (them 23a) (Type, Print) WALTER REED NATIONAL MEDICAL CENTER T. O'DONNELL, MD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

ack

32. Registrar's Signature

BETHESDA, MD 20889

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3:02 PM MAY Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** IMORE HARBOR HOSP ITA 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Funeral Min 234-30-8735 1 🗷 M 2 🗆 F 86 West Virginia July 30, 1925 **Director** 28a-f show 10d. Inside City Limits 10h County 10c. City. Town or Location Director Baltimore Examiner must be notified Maryland 1 ¥1 Yes 2 □ No o 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 21230 39 East Heath Street 23a Funeral "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12 Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.; Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. 2 [Baltimore, Maryland 21215-0036 ₩II 1 ☐ Yes 2 No Specify: White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7'. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. the Me Elementary/Secondary (0-12) College (1-4 or 5+) General Motors High Lift Driver Be 7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Negotha Berkley Theodore Kisamore မ 19b. Mailing Address (Street and Number or Bural Route Number City or Tayon, State, Zip Code)
39 Fast Heath Street Baltimore, MD 21230 19a. Informant's Name/Relationship (Type, Print) Melvin Kisamore, Jr. son 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date June 5, 2012 Glen Haven Menorial Park Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fully Polymak Funeral Home, P.A. 21. Signature of Funeral Service Licensee 237 East Patapsco Avenue Baltimore, MD 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of resulting in death) Last physician at s the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 as attending g IF FEMALE nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown Were autopsy findings available prior to completion of cause of 24a Was an page 2 autopsy certificate has death? performed 2 🗆 No 1 Yes 2 14 To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director; I Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 NO 1 Inpatient 2 I ER/Outpatient 3 I DOA 은 1 Yes 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work 5 Pending 1 Tes 2 No Investigation
6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of ce MD6x1 30. Name and address of person who completed cause of ceath (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

HARBOR HOSPITAL,

CTAWI

BALTIMORE MD

ROOI (HANGYERST

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Victoria W. King 14:55 PM MAY 2013

7. Age (In yrs. last birthday)

53

4b. City, Town, or Location of Death

Baltimore Cit If Under 1 Year | If Under 24 Hrs.

Hours

4c. County of Death N/A

9. Birthplace (State or Foreign

Maryland

8. Date of Birth (Month, Day, Year)

10/21/1958

Physician/ Medical **Examiner**

4a. Facility Name (if not institution, give street and number)

52 Social Segurity Number 3

Usual Residence of Decedent

Sinai Hospital of Baltimore

1 M 2 SKF

Funeral Director

28a-f shov at or than "natural", or items 23a or 28a-f s the Medical Examiner must be notified and is m

Baltimore, Maryland 21215-0036 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau

*Patient Known as Victoria Wendell King

Physician/ Medical **Examiner**

certificate be executed physician attending p page 2 certificate To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directors.

Box 68760

Division of Vital Records, P.O.

10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Xes 2 No N/AMD 10e. Street and Number 10g. Citizen of What Country? Funeral 21215 5801 Clover Rd. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 XNever Married 2 Married þ 1 ☐ Yes 2 🛣 No If Yes, Give 1 Yes 2 No Specify Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Pall Company Machinist 12th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Smith Raleigh Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ebonie King(daughter) 5801 Clover Rd., Baltimore, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 31/12 on-site Crematory 05/ Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Joseph Address of Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, I 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Metastatic Angiosarcoma Immediate Cause (Final disease or condition resulting in death) o months Due to (or as a consequence of): Sequentially list conditions, Due to for the automiconomic of cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year 1 Yes 2 No Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Homan Immunodeficiercy Vivas infection, Hepatitis C 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? infection 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier

Lestin D. Mann, M.D. 29c. License number 29d. Date signed (Month, Day, Year) RES-000 May 29, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Justin D. Mann, M.D. Sinai Hospital of Baltimore, 2401 W. Belredere Ave, Baltimore, MD 21215 31. Date filed (Month, Day, Year)
JUN 0 6 2012 32. Registra 's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Charlotte CEDM -aumann June 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Centr Alen Burni A runde & Coul Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Davs Hours Director 212-44-6695 1 🗆 M 2 🔀 F Maryland June 9,1945 66 Usual Residence of Deceden ir than "naturel", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 W No Pasadena Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21122 843 Swift Road U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married ۾ Maryland 21215-0036 1 ☐ Yes 2 M No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, should be fila and Mental H ၉ is marked Cincotta Angela Glaeser permit. Paga 1 and 2 should be Department of Health and Menl Important: If itam 27 is marke any injury or other treumatte s Frank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 843 Swift Road Pasadena, Maryland 21122 Joseph E. Laumann (Husband) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 06/06/2012 Glen Haven Mem. Pk. 21. Signature of Fugeral Service Licensee MOO-732 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. ad Pasadena, Marvland 21122 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardromyo te disease or condition a years Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): attanding physician end for usa as tha burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day 5 Other (specify) To the Hospital or Attanding Physician: The lew requires that the dae' within 24 hours effer death.
To the Funerel Director: After this certificate has been signed by the a' completaly filled in by the funeral director, page 2 should be detached forminetaly filled in by the funeral director, page 2 should be detached for the funeral director, page 2 should be detached for the funeral director. 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical Be **Division of Vital** 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Yes 1 Inpatient 2 K ER/Outpatient 3 IDOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) 512 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (600 Cram Site 206 31. Date filed (Month, Day, Year) 32. Registrar's State JUN 0 6 2012 Registrar

Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

aily Landa-Esc		Please Type of State of State (of Maryland	Departm		alth and Mei			20	12 1787	
Physici Medical Exam	an/	Decedent's Name (First, Middle, Last) Raily Aymerich Last)	anda–Esqu	ivel			2. I	Date of Death Month [fay 31, 201		3. Time of Death 0746 hrs	
		4a. Facility Name (if not institution, give 317 Braddock Avenue		Esquivo	Fre	, Town, or Location derick	of Death		4c. County of D Frederick		
Funeral Director		5. Social Security Number 6. Sex 218-98-7255		(In yrs. last bi		nder 1 Year If Und nths Days Hou		06/15/1		. Birthplace (State or or or or or or or or or or or or or	
nd show any sce.	_	Usual Residence of Decedent 10a. State 10b. County MD Frede	rick	10c. City, Towr	or Location	Frede	erick			10d. Inside City Limits 1 Yes 2 No	
th the Maryland 23a or 28a-f show	Director	10e. Street and Number 317 Braddock Avenue			10f. 2	Zip Code 217	01	10g	. Citizen of What	Country? USA	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mernal Hygiens and Thealth and Mernal Hygiens are Insportant. If item 27 is marked other than "natural", or items 22a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give Year or Dates:	X No	If Yes, spe	dent of Hispanic Or cify Cuban, Mexica 2 No specify	n, Puerto Rica Central v:	an, etc.) Americar	White, et Specify:	White	
036 vithin 72 hours ene. er than "natur Medical Exam	Completed I	15. Decedent's Education (Specify only Elementary/Secondary (0-12) 12	y highest grade com College (1-4 or 5		Decedent's Usu during most of v	al Occupation (Give vorking life. DO NO Representati	T use retired) VC	ins:		mer Service	
21215-0036 uid be filed within 7 Mental Hygiene. marked other than	Be		Diego Landa					Lidie	iden Surname) tte Esquivel		
MD 2. nd 2 should alth and M as 27 is m	٦ ک	19a. Informant's Name/Relationship (Tyr Cynthia Landa / Sister 20a. Method of Disposition	pe, Print)		4701 Ke	ess (Street and Nu nmore Avenu lame of cemetery,		07, Alexa		2304	
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 Burial 2 Cremation 3 Donation 5 Other Specify:		te crema	tory or other place sapeake Cr	ematory	6/6/2			sville, MD	
		21. Signature of Funeral Service Licenson Dorota Marshall 23a. Part I. Enter the disease, or complice	bulo 6h	arsha	∬ Maryl		n Service			imore, MD 21203	
Physician /Medical Examiner	e	failure. List only one cause on eac Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,		ve Carequence of):				pinatory arross	, stody of Hour	Between Onset and Death	
e executed ian and ial - transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	ue to (or as a conse	quence of):							
50, te be exec hysician ar	cian/Medical	X UNPENDED X	AMENDED 23a, 1, per me, 23c. If yes, outcom			ne,g928 6- sm 5 per	-22-12 fh g9	sm 28 6-2	6-12 vt 23d, Date of deli	verv	
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be with a bours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 4 Pregnant at t	inne of death	Fetal dea Other (S		ic pregnancy		Month	Day Year	
S, P.O. I	百	Part II. Other significant conditions of Morbid Obesity	contributing to death	but not resultir	ig in the underlyi	ng cause given in P	Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown			
of Vital Records, ng Physician: The law require After this certificate has been simmeral director, page 2 should b	Completed							24a. Was an autopsy performe	prior ed? deat		
Vital Recystrian: The this certificate director, page	To Be (25. Was case referred to medical examiner? 1 Yes 2 No	spital: 1 Inpatier	it 2 ER/O	utpatient 3	26.Place of Death			esidence 6 🗸 O	ther: Scene	
on of canding Pheath.		27. Manner of Death 1 X Natural 5 Pending	28a. Date of Injur (Month, Day,Ye	y 28b. ar)	Time of Injury	28c. Injury at Wor	k? 28d	. Describe how	v injury occurred		
Division Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: /	Certification:	3 Suicide 6 Could not be determined	28e Place of Init	ıry - At home, f	arm, street, facto	ry, office building, e	etc. 28f.	Location (Stre or Town, Stat		Rural Route Number, City	
Fo the Hos within 24 ho completely	Medical (
	Σ	29b. Signature and title of certifier Hernyth Pouthull,	mo		2	O.C.M.E.	r 		9d. Date signed ((Month, Day, Year)	
Ø v			Assistant Medic	al Examine	er 900 W. E	Baltimore Stree	t, Baltimor	e, MD 212	23		
Si	ate	31. Date filed (Month, Day, Year)	2 32. Registrar	s Signature							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Eric Robert Larsor	1- For State Registrar		-	•	ment of <i>icate of</i>	Health and Death	Mental		Reg. No.	201	2 1787
Physician Medical Examine		e (First, Middle,Las bert Lar						2. Date of Dea Month May 31, 2	Day	Year	3. Time of Death 1910 hrs
	4a. Facility Name (if not institution, giv Chesapeake D		per)	14	b. City, Town, or L Bel Air	ocation of De		40	County of Deat	h
Funeral Director	5. Social Security N 219-04-21	15 1x	9X 7	Age (In yrs. last I	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bi Min. 12/22		Forei	rthplace (State or gn puntry) MD
kow .	Usual Residence of 10a. State	10b. County		10c. City, Tox	wn or Location	on					10d. Inside City Limits
yland yland once.	MD 10e. Street and Nu	Harf	ord	E	Bel Ai	r 10f. Zip Code				()40 10	1 Yes 2 No
h the Maryland 3a or 28a-f sh otified at once	202 Point		t Square			21015			USA	zen of What Cou	intry?
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho fraumatic event, the Medical Examiner must be notified at once. To Be Commissed by Eumeral Director	11. Marital Status 1 Never Marrie		Armed Ford	ent Ever in U.S. es? 2 🔀 No	If Ye	es, specify Cuban,	Mexican, Pue	(Specify Yes or No erto Rican, etc.))-	White, etc.	ican Indian, Black,
urs afte	3 VVIdowed	4 Divorced lucation (Specify or	If Yes, Give Year or Dates: nly highest grade	completed) 16	a. Decedent	Yes 2 No	on (Give kind		16b. i	Specify: W11 Kind of Business/	
5-0036 led within 72 hour sygiene. other than "natu the Medical Exan	Elementary/Seco	ndary (0-12)	College (1-4	or 5+)	during mo	st of working life. [ef	DO NOT use	retired)	Re	stauran	t
5-00. Hed with Hygiene I other to the Merita Com	17. Father's Name (I		18		ame (First, Middle, I	Maiden	Surname)	
21215-0036 ould be filed within 7 d Mental Hygiene. s marked other than tie event, the Medica			ype, Print)	11	19b. Mailing			E. Lane	nber, Ci	ity or Town, State	a. Zip Code)
e, MD and 2 sho Health and Item 27 is r fraumati	Rhonda E.	0		2	202 Po	int to P	oint S	q., Bel	Air,	MD 210	15
2	1 K Burial 2 6	Cremation 3 Other Specify:		ctoto crem	atory or other	m'l Gard	ens 06	Date /04/2012	Ве	Location - City or	MD
Baltimo permit. Page Department o Important: injury or ott	21 Signature of Fur	- /	Dur k	~				chimunek Rd., Bel			
Physician ৃ/Medical	23a. Part I. Emer the failure. List onl	e disease, or compl y one cause on ea	ch line.		not enter the	e mode of dying, si					Approximate Interval Between Onset and Death
Examiner	Immediate Cause (I or condition resultin	g in death)	Oue to (or as a co	nsequence of):	cation	1					
je L	Sequentially list cor if any, leading to im cause. Enter Under	mediate [Oue to (or as a co	nsequence of):							
ted Insit	(Disease or injury the events resulting in contact the	at initiated C.	Due to (or as a co	nsequence of):							
0, e be executed ysician and burial - transit	X UNPENDED		AMENDED23	a,27,28a	-f,pe	me,g928	3 6-8-	12 sm			
Division of Vital Records, P.O. Box 68760 to the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bused called the funeral control of the funeral director.	IF FEMALE: 23b. Was decedent past 12 months' 1 Yes 2 N	?	1 Live birth	at time of death	2 Feta	Il death 3	Ectopic pre	gnancy	1	I. Date of delivery Month [Day Year
ires that the signed by the detache		cant conditions	contributing to de	eath but not result	ing in the un	derlying cause giv	en in Part I.		_		the cause of death?
Division of Vital Records, lat or Attending Physician: The law requires rs after death. al Director: After this certificate has been signed in by the funeral director, page 2 should be striffication: To Be Completed				-				24a. Was a	an sy med?	24b. Were au prior to death?	topsy findings available completion of cause of
Vital Recystein: The Inspection of the Court			ospital: 1 Inpa			To.	f Death (Che	ck only one)			
of Vir ling Physte After this funeral dir.	1 Yes 2	NO NO	28a. Date of I	njury 28b	Outpatient . Time of Inji			sing Home 5 28d. Describe h			·
Sion C Attending r death. ector: Aft by the fun cation:	1 Natural 2 Accident	5 Pending Investigation		31-12 fo	1 6:32	РШ	s 2 🗶 No	unknown			
Divis Biptial or At hours after d neral Direct of filled in by Certifica	3 Suicide 4 Homicide	6 X Could not b	e 28e. Place of (Specify)	Reside		factory, office buil	lding, etc.		tate) 2		ral Route Number, City to Point).
Division To the Hospital or Attent within 24 hours after death To the Funeral Director completely filled in by the				xamination and/or		n, in my opinion, d	leath occurre				
	All	Bross	ellab	A	-	29c. License r			ı	Pate signed (Mor	nth, Day, Year)
0	30. Name and addre					Baltimore Stre	eet, Baltim	nore, MD 2122	:3		
State Registrai	31. Date filed (Month	N 0 6 201	32. regis	trar's Signature	bar	w					
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12-04075

amend #1,per me,g928 6-26-12 sm
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Bobby Laws		State Registrar	e of Maryland /		ent of Health a ate of Death	and Men		eg. No. 20	2 787	
Physician	n/	 Decedent's Name (First, Middle, La 	•				Date of Dea Month	ath Day Year	3. Time of Death	
Medical Examin	Θl	Bobby Lee Laws 4a. Facility Name (if not institution, g	be street and number)	Lee Law	4b. City, Town,	or Location o	May 29, 2	2012 4c. County of Dea	1254 hrs	
		8030 Gough Street	ve strock and nambor,		Baltimore		or Boatt	Baltimore Co		
Funeral Director		5. Social Security Number 6. S 218-84-6313	Sex 7. Age	(In yrs, last birt		ear If Unde	1 10	rth (MM/DD/YYYY) 9. E	Birthplace (State or Bign Country) Maryland	
Aug	F	Usual Residence of Decedent 10a. State 10b. County		I0c. City, Town	or Location				10d. Inside City Limits	
>	اي	Maryland Baltimo	i		point				1 Yes 2 No	
Aarylau 28a-f s 1 at on	Director	10e. Street and Number			10f. Zip Code	•	1	Og. Citizen of What Country?		
h the N	֓֞֞֜֞֜֞֜֞֜֞֜֜֞֜֜֡֓֜֜֜֜֡֡֡֜֜֜֡֡֡֡֡֡֡֡֡֡֡	8030 Gough Stre	et		2122	24		U.S.A.		
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 77 is marked uther than "natural", or items 23a or 28a-f shan injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 X Marrie	1 Yes 2 X	ver in U.S.	If Yes, specify Cub	oan, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	White, etc.	erican Indian, Black,	
ural",	ᇗ	Widowed 4 Divorce Divorce Specify 6	d If Yes, Give Year or Dates: only highest grade comp	oleted) 16a. I	1 Yes 2 X I		sind of work done	Specify: Wh		
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within iene.	틹	10	_	Ι	eck Hand			Waterman		
of filed all Hyg	ညို ရှိ	 Father's Name (First, Middle, Las Bobby Lee Laws 	*				s Name (First, Middle, i ty Ann Matl			
212 ould bould by Ment		19a. Informant's Name/Relationship (Type, Print)	191	o. Mailing Address (Str				te, Zip Code)	
MD and 2 shalth an alth an an 27 i	L	Dawn M. Laws: 1 20a. Method of Disposition	Vife	1	302 Pennsy	lvania	Avenue, Ha	gerstown M	aryland 21742 or Town, State	
Ore, ges 1 as 1 of He if ther th		1 Burial 2 Cremation 3	Removal from State	cremate	ory or other place)					
Itim ii. Pag utmen	ŀ	4 Donation 5 Other Specification of Funeral Service Lice		Arden	t Cremation			Hanover,		
Dep Dep Initial	d	muchael P man	4/60-		buuy Harro	ora Ko.	ad, Baltimo	Funeral Cha ore,Maryla	apel,P.A. nd 21214	
Physician //Medical		23a. Part I. Enter the disease, or comfailure. List only one cause on e	plications that caused the ach line. Hypert	ne death. Do no	t enter the mode of dyin	ng, such as ca	ordiac or respiratory arm	est, shock, or heart ar Disease	Approximate Interval Between Onset and	
Examiner	- 1	Immediate Cause (Final disease a or condition resulting in death)	Hypertensia Due to (or as a consequence)	ve Card	iovascular	Diseas	se		Death	
	-	Sequentially list conditions, b		dones ory.						
		if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conseq	uence of):					4	
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ion of Vital Records, P.O. Box 68760, tending Physician: The law requires that the death certificate be executed teath. To see 2 should be detached for use as the burial - transit the funeral director, page 2 should be detached for use as the burial - transit arion: To see Completed by Dhysician Medical Execution				3a,pt.I	L, 27, per m	e,g928	6-22-12 sı	m		
760, ficate be g physici the buri	23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy						23d. Date of delive			
Box 6876: e death certificate the attending phy ed for use as the b	2	past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month							Day Year	
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Division of Vital Records, tal or Attending Physician: The law requing all pire death. a) Director: After this certificate has been siled in by the funeral director, page 2 should burification: To Be Commission.		25. Was case referred to medical			26.Pla		Check only one)		2 110	
n of Vital Jing Physician: After this certiff funeral director,	26	examiner? 1 Yes 2 No 7. Manner of Death	Hospital: 1 Inpatient		tpatient 3 DOA			Residence 6 🗸 Oth	er: Scene	
nding of	5 2	1 X Natural 5 Pending	28a. Date of Injury (Month, Day, Yea		-	jury at Work? Yes 2	ľ	now injury occurred		
r Atter rer deal rector rector n by th	<u> </u>	2 Accident Investigat	28e Place of Injur	ry - At home, fai	rm, street, factory, office			Street and Number or R	ural Route Number, City	
Division O Bostial or Attending 14 hours after death. Funeral Director: After filled in by the fun		4 Homicide determine					or Town, S	tate)		
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		9a. Certifier 1 Certifying Physic Check only 2 Medical Examine	ian: To the best of my in the basis of examinand manner stated.							
H 3 H 3	2	9b. Signature and title of certifier				nse number		29d. Date signed (M	onth, Day, Year)	
		metic	- A H - KK		0.0	C.M.E.		May 30, 2012		
	13	O. Name and address of person who Ana Rubio M.D., Ph. D.	completed cause of dea Assistant Medica		900 W. Baltimo	re Street.	Baltimore, MD 21	223		
Stat	~	11. Date filed (Month, Day, Year)	32 Registrar's							
Registra	_	JUN 0 6 201	Cenar	B. A	back					
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tems 19a per fb 21 per dyr 9928 6-7-12 by State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Physician/ 4:24 A M William Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Medical University of Maryland Baltimore N/A Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours (Month, Day, Year) 217-62-2103 1 **№** M 2 🗆 F Director 56 05/28/1956 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland at Funeral Director notified 1 X Yes 2 🗌 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 6 10g. Citizen of What Country? r items 23a or iner must be n 5435 Todd Ave. 21206 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) years Market Conduct Examiner MD Insurance Admin. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ William F. Leach Ora Blow 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
21207
Paltimore, MD 2120 19a. Informant's Name/Relationship (Type, Print) Myra Staples (sister) 5709 Pembroke Ave., Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State on-site Crematory Cololla 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, 21. Signature of Euneral Service Licenses 305cord Hs. FBrown Jr. Funeral Home PA 21217 2140 N. Fulton Ave., Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ Mantle disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Physician/Medical Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. the settificate has been signed by the attending physician and the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or injury attending physician and for use as the bunal-trar that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death
9 Unknown Month Day Year been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed? Yes 2 No 1 🗆 Yes 2 🗆 No 25. Was case referred to medical director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD P27224 2012 51 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21201 Britton MD 22 9. ST. Baltimore Justin Green 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2012 **IUN 0 6** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 10d,26 per fh/verb., g928,06/06/2012dhb

Certificate of Death

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MISTROFF Month 05 Physician/ SIDNET 3.20AM 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death aven HIMOVE Social Security Numbe **Funeral** Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 🗆 F 87 Months Days Hours Min. (Month, Day, Year) 216-14-0543 Director Yrs Maryland 1924 Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 Yes ZENO 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 4516 Harcourt Road 21214 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ yes 2 □ No If yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Specify. Completed 3 Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Sales Manufacturing Be permit. Page 1 and 2 should be flied Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other them. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry Mistroff Rita Yaffee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oma Mistroff /Wife 4516 Harcourt Road Baltimore, MD 21214 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date May 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland Chesapeake Crematory 2012 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. NanGrendateson Family Funeral Alternatives M01443 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine in any, leading to immediate cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequ Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death detached Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? Yes 2 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: မြ 1 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28b. Time of Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending s after death. 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 2 To the 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

ex1

Registrar

DHMH 17 Rev 7/2009

State

30. Name_and address of person who completed ca

JUN 0 6 2012

MESID

ABISOLA

31. Date filed (Month, Day, Year)

3900

se of death (Item 23a) (Type, Print)

D0070441

Raven

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 1-Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Rosemarie Becker Molsky 6 2012 6:15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ingleside at King Farm Rockville Montgomery Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2√2 F 1-12-1926 **Director** 86 New York 119**-**16-5115 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f shov item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Madical Evancing must be relifted at 1 X Yes 2 □ No MD Director Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 701 King Farm Blvd. 20850 United States death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 72 hours after 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify Specify: White þ X☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 Office Administrator Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nathan Becker Clara Hafner ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20879 Health a Michael Sternfeld - Nephew 18343 Honeylocust Circle, Gaithersburg, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 Department of Important: If it any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6-7-2012 Riverside Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Saddle Brook, New Jersey 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Danzansky-Goldberg 1170 Rockville Pike, Rockville, Maryland 20852 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Stroke Days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Atrial Fibrilation Years Sequentially list conditions, if any, leading to immediate cause. Enter the chiral Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-transi Hypertension Years and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day 5 Other (specify) detached 9 Unknown 9 Duknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an has director, page 2 s autopsy certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident completely filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760 P.O. Division of Vital Records, Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica e Funeral I

Saltimore, Maryland 21215-0036

To the within 2 0

State Registrar

Medical

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

1DC certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

D34590

6-5-2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elliot Fried, MD - 7758 Wisconsin Avenue, Bethesda, Maryland 20814

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

(Check only

32. Registrar's Signature

and manner stated.

JUN 0 6 2012

Charles Marshall		e of Maryland	d / Depa	artment of	Health and			0.1	1100
	1- For State Registrar		Cei	rtificate of	Death			eg. No. 21	
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,L CHARLES HENR	Y MARSHA		R.			2. Date of Dea Month May 29, 2	Day Yea 012	1240 nrs
	4a. Facility Name (if not institution, g University Hospital	give street and number	er)	4	b. City, Town, or L Baltimore	ocation of Deat	h	4c. County of	of Death
Funeral	5, Social Security Number 6.	Sex 7.7	Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24Hr	_	th (MM/DD/YYYY	9. Birthplace (State or Foreign
Director	219-16-0403	X M 2 F	85	Yrs.	Months Days	Hours Mir	07/26/	1926	Country) MD
any	Usual Residence of Decedent 10a, State 10b, County		I10c City	Town or Location	in .				10d, Inside City Limits
		Coomaca		.dover					1 Yes 2 No
the Maryland a nr 28a-f sh tified at once Director	MD Prince 10e. Street and Number	Georges	Lan	dover	10f. Zip Code		1	0g. Citizen of Wh	nat Country?
r death with the Maryland or items 23s nr 28s-f shn must be notified at once. Funeral Director	7711 Oxman Rd.				2078	5		USA	
r death with or items 23 must be no Funeral	11. Marital Status	12. Was Decede			Decedent of Hisp s, specify Cuban,			- 14. Race White	- American Indian, Black,
or ite	1 X Never Married 2 Marrie	1 Yes	2 X No		_				
urs afte	3 Widowed 4 Divorce 15. Decedent's Education (Specify	ed If Yes, Give Year or Dates: only highest grade o	ompleted)		Yes 2 No		work done	16b. Kind of Bu	Black siness/Industry
72 hou	Etementary/Secondary (0-12)	College (1-4 c		during mo	st of working life. (OO NOT use ref	tired)		
5-0036 ed within 72 hours lygiene "natu other than "natu the Medical Exan Completed	6th			Forkli	ft Opera				Company
	17. Father's Name (First, Middle, La		T aa		18		e (First, Middle, I s Smith	Maiden Surname)	•
2121 ould be fil d Mental Is s marked tic event,	Charles Henry M 19a. Informant's Name/Relationship		DI •	19b. Mailing	Address (Street			nber, City or Tow	n, State, Zip Code)
MD 12 sho th and 1.27 is namati	Mary Lee Marsha	11- Siste	r	7711	Oxman Rd	. Land	over, MI		
re, l	20a. Method of Disposition 1 X Burial 2 Cremation	_	20b. I	Place of Disposit crematory or other	ion (Name of ceme er place)	etery,	Date	20c. Location -	City or Town, State
Page:	4 Donation 5 Other Speci	fy:			on Cemet			Clintor	
Baltimore, vernit. Pages I at Department of Hee Important: If the Injury or other tr	21. Signature of Funeral Service Lice	ensee	10		ghad1ddrmag				
Physician	23a. Part I. Enter the disease, or cor	nplications that cause	ed the death.		8 Suitla: e mode of dying, s				
/Medical	failure. List only one cause on Immediate Cause (Final disease	each line. a. Complica	tions	of Peri	heral Va	scular l	Disease		Between Onset and Death
Examiner	or condition resulting in death)	Due to (or as a cor	sequence o	f):					
5	Sequentially list conditions,	b. Atherosc			ovacsula	r Disea	ise		
ted Insit Examiner	cause Enter Underlying Cause	c							
tecuted t and transit	events resulting in death) Last	Due to (or as a cord.	isequence of	f):					
େ ଲେଲା ⊆ା		X AMENDED #1	, 23a-t	pt.II,	27,per m	e,g931	9-20-12	SM	
760, icate be physicia the buris	IF FEMALE:	23c. If yes, outo	ome of preg	nancy			-	23d. Date of	
ox 687 eath certific attending for use as t	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant	at time of de	-11 -	aldeath 3 ∟ er (Specify)	Ectopic pregn	ancy	Month	Day Year
). Box 68760, the death certificate be the death certificate be by the attending physic ched for use as the bun Physician/Med	1 Yes 2 No 9 Unknow			J Oth	er (Specify)				
P.O. s that the gned by the detache	Part II. Other significant condition	-							bute to the cause of death?
S, P juires t m sign ld be c	Spinal Stenosi	is, Hypert	ensive	e Cardio	vascular	Diseas	24a. Was		Probably 4 Unknown Vere autopsy findings available
ords, aw requir nas been s 2 should	 						autop	osy p	rior to completion of cause of leath?
Division of Vital Records, P.O. Box 68760, to the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buried in the funeral director. To Be Completed by Physician/Med					00.81	10. 11.101	1 Yes		Yes 2 No
/ital /sician: nis certi director	25. Was case referred to medical examiner?	Hospital: 1 / Inpa	tient 2	ER/Outpatient		of Death (Check other Nursi		Residence 6	Other:
n of Viding Physical After this funeral dir	1 Yes 2 No 27. Manner of Death	28a. Date of Ir (Month, Day	njury	28b. Time of In		at Work?	28d. Describe	how injury occurre	ed
ion tendin eath. for: A the fu	1 X Natural 5 Pending 2 Accident Investiga		,, r car)		1 Ye	s 2 No			
Division o spital or Attending hours after dearl hearl Direct dearl filled in by the fune Certification:	3 Suicide 6 Could no	ot be 28e. Place of	Injury - At ho	ome, farm, street	, factory, office bui	ilding, etc.	28f, Location (S or Town, S		er or Rural Route Number, City
Divis	4 Homicide determing 29a Certifier 1 Certifying Physics	(openy)			ad at the time date	and place on	d due to the sour	co(s) and manner	as stated
To the Hos within 24 h To the Fur completely	(Check only 1 Certifying Phys one) 2 ✓ Medical Examin	ician: To the best of er:On the basis of ex	amination a	ge, death occum nd/or investigation	on, in my opinion, o	e and place, and death occurred	at the time, date	and place, and d	ue to the cause(s)
To To To	29b. Signature and title of certifier	and manner_state	<u>a.</u>		29c. License	number		29d. Date signe	ed (Month, Day, Year)
	0-2				O.C.M	l.E.		May 30, 20	12
	30. Name and address of person wh	·			N/ Delti	Stroot Dati	more MD 04	222	
NO	Donna M. Vincenti, MD 31. Date filed (Month, Day, Year)	Assistant Med	lical Exan		V. Baltimore S	oneer, Baitii	nore, MD 21	223	
State Registrar	JUN 0.6		ma.		Kel				
DHMH 17 Rev 1/2001		OCME	•	ORIGINAL					

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0:54P M Robert D. McGinnis June 2012 Medical 4a. Facility Name (if not institution Examiner 4c. County of Death Hinore Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Min. Hours Country **Director** 1 X M 2 D F 90 MD 7/22/1921 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 Yes 2 X No Windsor Mill MD Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral 21244 USA 2930 Kuntz Rd. 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Armed Eorces? 0 Completed by 1 Never Married 2X Married 2 No 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced White Year or Dates. WWII event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Supervisor C & P Telephone Co. Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental F ပ Ella Becraft Richard Eugene McGinnis and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 2930 Kuntz Rd., Windsor Mill, MD 21244 Charlotte B. McGinnis/Wife Important: If iten any injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1

■ Burial 2

Cremation 3

Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/6/2012 Randallstown, MD Olive Cemetery Signature of Funeral Service License 2Burraerd One EnlivFuneral Home & Crematory, 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Inset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying DENTIFICATION APPROVED BY MEDICAL EXAMINER Examine Due to (or as a consequence of): Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has autopsy perforp death? Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Yes 2 🗌 No Certificate: To Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending UNK Fell down Stairs 2 **Y** No 2/2012 1 Yes Subject within 24 hours after death To the Funeral Director: / completely filled in by the Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) WINGSOT MILL, 4 Homicide determined Home 2930 Road KUNTZ 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To be best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital of Baltimore YOUSSEF 31. Date filed (Month, Day, Year, State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Michael J. Matthews Month Physician/ 530 PM 2012 6 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN SQUEETE BalTimor Roseda HOSPITa 7. Age (In vrs. last birthday) If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Month, Day, Year), 1949 Hours 213-54-0832 MD 62 Director 1 🗶 M 2 🗆 F Usual Residence of Decedent or 28a-f show notified at 10a State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Baltimore MD Baltimore 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? items 23a or ner must be n 21224 USA Funeral 432-B Oriole Avenue death . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status "natural", or itel edical Examiner Armed Forces?

1 XYes 2 No Black, White, etc. þ 1 Never Married 2 Married 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify White Completed 3 Widowed 4 Nivorced er than "natur, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha GM Mechinist Be 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) ပ Ruth S. Miller Frank J. Matthews traumatic and 2 should b Health and Mer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Important: If item 27 is any injury or other trat once. 7636 Donny Terrace Kingsville MD 21087 Patricia Prill /sister Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State malli 20a. Method of Disposition of ☐ Burial 72 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 6/6/12 Baltimore MD 4 Denation 5 Other (Specify) 22. Name and Address of Facility eral S 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Narc otic INTOxication Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical The law requires that the death certificate be Box 68760 attending p IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic preana in the past 12 months? Month 5 Other (spec Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has page 2 1 Yes 2 No certificate Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Ves 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☑ No 28b. Time of 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After t
completely filled in by the funera 1 Natural 2 Accident 5 Pending overdose 5-28-2012 110 Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 2122C) determined City or Town, State) 62 Honey comb Rd Home Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 72785 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Khalil 9000 FAAnklin Sauare DR Balto Md Ayesha 31. Date filed (Month, Day, Year, 32. Registrar's gignature State JUN 0 6 2012

Registrar

7

State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year JUNE Sandra Ann Mogavero 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death C-LEN BURN ANNE Baltimore-Washington Medical Center Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 11/24/1945 Maryland 1 🗆 M 2 🔀 F Director 579-58-7204 66 Yrs Usual Residence of Dece items 23a or 28a-f show her must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1406 Mara Vista Court 21666 within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. the Medical Examiner Black, White, etc. ō þ 1 Never Married 2 Married Yes Yes, Give 2X No 1 ☐ Yes 2X☐ No Specify: Completed 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Transportation Assistant Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis Elder Wightman, Sr Marjorie Elizabeth Beacht 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christina Ann Maggio / Daughter 910 May Lane, Stevensville, MD 21666 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Chesapeake Crematory 6/7/2012 Beltsville, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Pnysician CHRONIC OBSTRUCTIVE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 👿 No Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 K Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pertorm 1 ☐ Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🔀 No Other: 은 1 X Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 🔀 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a, Certifie 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier D0061832 JUNE 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 HOSPITAL DRIVE GLENBURNIE, State 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indefible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 05 Day 30 Physician/ 2012 A^{M} John Francis McLaughlin 9:20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Terraces At Edenwald Baltimore Towson 1 Year 5. Social Security Number . Age (In yrs. last birthday) If Under If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min (Month, Day, Year) 10/10/1918 93 Director 029-05-9672 Massachusetts Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland al Hygiene. 10a. State 10c. City. Town or Location 10d. Inside City Limits Directo 1 X Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 800 Southerly Road SH 228 21286 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 2 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify 3 X Widowed 4 ☐ Divorced Completed White the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 6 Merchant Marine Shipping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o Leo Bernard McLaughlin Catherine Veronica Devin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leo McLaughlin / Son 4716 Sportsman Club Road, Spring Grove, PA 17362 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🛣 Cremation 3 🗀 Removal from State any injury or 4 Donation 5 Other (Specify) Chesapeake Crematory 6/3/2012 Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility 1. Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nd Death Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month 4 Pregnant Pregnant at time of death Yes 2 No the detached 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an cate has page 2 s autopsy death? this certificate 1 🗌 Yes 2 🗌 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Che only one) Be ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner eath 28b. Time of Certificate: 28d. Describe how injury occurred iniurv 5 Pending Natural n 24 hours after death.

e Funeral Director: After the furthe further the furt 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medica Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only or 29b. Signature and title of certi 29c. License number 29d. Date signed # hth, Day, Year

State Registrar

JUN 0

6

Baltimore.

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene 7888 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 6 Physician/ I. Mal 210 2101 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ineton Med. ral Center If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Hours Country) Director 92 080-12-9214 1 XM 2 □ F 04/29/1920 NY Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Director Pasadena Anne Arundel 28a-f MD 1 ☐ Yes 2X No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral USA 21122 8231 Green Ice Drive tems 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Examiner Black White etc ō þ 1 Never Married 2 X Married Yes 2 Xo Yes, Give be filed within 72 hours after Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XNo Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation Decedent's Education 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) d Mental Hygiene. marked other tha NY City Fire Dept Fireman event, the 14 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Madeline Marotto Felice Malfi and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Marie Malfi Wife 8231 Green Ice Drive Pasadena MD 21122 t. Page 1 and 2 sh rtment of Health a rtant: If item 27 i other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Department of Important: If it any injury or o ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 6/3/2012 Glen Burnie MD Atlantic Crem 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licenses 22. Name and Address of Facility Simplicity Crem & Fun Serv Signature Thomas Allen P. A. 7090 Ridge Rd HanoverMD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury eu mon that initiated events the burial-trai resulting in death) Last Due to (or as a consequence of): physician by Physician/Medical death certificate be Box 68760 use as ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) attending IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No for Month ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has the lirector, page 2 s autopsy perform Yes 2 or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 X No 1 Yes 1. Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred after death. Director: After injury work?
1 Yes 2 No 1 X Natural 5 Pending Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours at To the Funeral Di Hospital Medical 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00010816 Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 110 5 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^D2012 Physician/ Martina Eleanore Mevers June 9:16 P.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Baltimore Timonium Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Hours (Month, Day, Year) 212-38-4940 Director 1 □ M 2 🖔 F 79 March 6,1933 Germany Usual Residence of Decedent 10b. County itam 27 is markad othar than "naturel", or itams 23a or 28a-f sho othar traumatic avant, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 U.S.A. 2522 Wendover Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Ś Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry parmit. Paga 1 and 2 should be filed within 72 h. Dapartment of Heelth and Mental Hygiane. Important: If fam 27 is markad other than "na any injury or other traumatic avant the page. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Carpenters Helper Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Schmitt Augusta Ruesas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2522 Wendover Road, Baltimore, Maryland 21234 19a. Informant's Name/Relationship (Type, Print) Louis P. Meyers: Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Ardent Cremation, Inc. 6-5-12 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Hanover, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. michael P. marulle 6009 Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SEPSIS Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) burlel-trer Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy for t Day Pregnant at time of death 5 Other (specify) 24 hours efter death.
a Funeral Diractor: After this certificeta has bean signed by the a letely filled in by the funaral diractor, pega 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical 8 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) HOSPICE မ 1 🗌 Yes 2 🗶 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 2 Accident 3 Suicide injury 5 Pending work? 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier npletely f (Check To tha within 2 To tha I complex only one 29b. Signature 29d. Date signed (Month, Day, Year, 012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) Registrar's Signature State <u> JUN 0 6</u> Registrar

p.m.

JUNE

MARTINA MEYERS

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 30 per dyr g928 6-6-12 yt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Marian E. Mullineaux May 23, 2012 Year 4:45 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Mt. Airy Carroll Lorien of Mt. Airy 8. Date of Birth (Month, Day, Year) Sep 18, 1916 Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours Min. Months 215-22-0972 95 Director 1 M 2 DE Usual Residence of Decedent 28a-f shov 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD **Baltimore** Landsdowne 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country Funeral 1936 Victory Dr. 21227 U.S.A. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 be filed within 72 hours after White 1 ☐ Yes 2 ♠No Specify: than "natural", If Yes, Give 3 ⋈ Widowed 4 □ Divorced Year or Dates. injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene, is marked other tha Clerical Worker Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ William Lowrey Mildred Little permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1936 Victory Dr. Halethorpe, MD 21227 Herbert B. Mullineaux 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 → Burial 2 Cremation 3 Removal from State May 31, 2012 Crest Lawn Memorial Gardens Marriottsville, Maryland 4 Donation 5 Other (Specify) 22. Name act Address of Facility ome, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 of Funeral Ser Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HEART STIVE disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events physician and s the burial-transit death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ate has been signed by the atte page 2 should be detached for in the past 12 months? Month Day Year Pregnant at time of death Unknown 2 No 9 Unknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RINIC OBSTRUCTIVE 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 1 Yes 2 No 2 12 No Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify eral Director: After thi filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours Medical 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) of certifie 29b. Signature and titl 29d. Date signed (Month, Day, Year,

Registrar DHMH 17 Rev 06-2011

State

Asha Vali

31. Date filed (Month, Day, Year)

DOOL 2861

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9801 Georgia Ave. #118 Silver Spring, Md. 20902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	artment of Health and N	/lental Hygie	ne		
				rtificate of Death	Reg.	No. 2012	17891	
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death	
	Medic	al	Steven Wayne Needham 4a. Facility Name (if not institution, give street and number)	the Other Transport Country of Double	May	Day Year 2012	2:13 A ^M	
	Examin	ier	9160 Old Scaggsville Road	4b. City, Town, or Location of Death Laurel		4c. County of Death		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Howard 9. Birthpla	ice (State or Foreign	
	Director		216-64-3528 1X M 2 □ F 57 Yrs.	Months Days Hours Min.	(Month, Day, Yea			
	nd how at	<u>_</u>	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation	bury 22,		d. Inside City Limits	
	faryla 8a-f s tified	Director	MD Howard Laurel				1 ☐ Yes 2 🛣 No	
	the N a or 2	اقا	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Countr	y?	
	h with	Funeral	9160 Old Scaggsville Road	20723		USA		
	r iten		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Never Married} \) Never Married 2 \(\text{XMarried} \) Married 1 \(\text{Never Married} \) 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americar Black, White, etc		
920	s after al", o Exam	d by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates.	1 ☐ Yes 2X No Specify:		Specify: Wh	ite	
Ö 2	hour natur dical	Completed	15. Decedent's Education 16a. Dece	dent's Usual Occupation	. 165	o. Kind of Business/Indu		
2	hin 72 ne. than " e Me	omk	Elementary/Secondary (0-12) College (1-4 or 5+)	kind of work done during most of work O NOT use retired)	ing			
5	ed with	Be C	10th Ø Ca	rpenter	/F: 1.15:17:18	Construct	ion	
Baltimore, Maryland 21215-0036	be filk ental ked c	To	James Ellis Needham		e (First, Middle, Maid + hy Louise	en surname; e Houchens		
ary	hould and M s mar			ng Address (Street and Number or Run	-		de)	
Σ,	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Health and Mental Hygiene. The marked other than "tratural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Eileen Marie Needham/Wife 9160	Old Scaggsville	Road, Lauı	rel, MD 20	723	
ore	ye 1 a t of H If ite or oth		20a. Method of Disposition 1	sition (Name of natory or other place)	Date 20d	c. Location - City or Tow	n, State	
를	errit. Page 1 l exartment of Important: If is eny injury or c		4 Donation 5 Other (Specify) St. Mary	's Cemetery 6/4/		aurel, MD		
Ba	era lega lmpo any ii		21. Signeture of Funeral Service Licensee AMD WWW M01103	2. Name and Address of Facility DOI				
			23a. Part / Enter the disease, or complications that caused the death. Do not ent	313 Talbott Ave			D /	
- 1	h, sician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease ir condition Diabetes Me	llitus Type II		li li	nterval Between Onset and Death	
	Medical		resulting in death) a. Due to (or as a consequence of):	TIICUS TYPE II				
	Examiner	r e	Sequentially list conditions, b.					
	pe psit	Examiner	if any, leading to immediate Due to (or as a consequence of): Cause (Disease or injury					
	executed ian and irial-transit	Еха	that initiated events c. resulting in death) Last Due to (or as a consequence of):					
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_	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	/Med	IF FEMALE:					
Box 687	ath ce attend for us	cian/	23b. Was decedent pregnant in the past 12 months? 1 Ve 2 bts 12 months? 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delivery Month D	ay Year	
ŭ	The law requires that the death atte has been signed by the atter page 2 should be detached for	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5 L g Unknown	Other (specify)				
л. О	that t ned by e deta	by PI	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	co use contribute to the	cause of death?	
ds,	quires en sig ould b		Multiple Sclerosis		1 ☐ Yes	2 X No 3 ☐ Proba	oly 4 🗆 Unknown	
00	law re las be e 2 sh	Completed	CVA		24a. Was an autopsy	prior to comp	y findings available Detion of cause of	
Ž	The cate h				performed 1 Yes 2 X	? death? 1 ☐ Yes 2	€ No	
Ta	sician certifi irecto	m	25. Was case referred to medical examiner? 1	26. Place of Death (Check				
10	g Phy er this eral d	e: To	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at	me 5 LXResidence 28d. Describe how in	e 6 Other (Specify)		
0	endin sath. or: Aft. he fur	ficat	11√X Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	work? M 1 ☐ Yes 2 ☐ No				
Division of Vital Records,	or Att	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Reate)	oute Number,	
The part of the pa								
			In mo	D56797		May 29, 20	L2	
	101		30. Name and address of person who completed cause of death (Item 23a) (Type, F Lalitha Tadikonda, 13952					
	Stat	е	31 Date filed (Month Day Veer)	Baltimore Avenue,	⊥aureI, M	ID 20707		
	Registra	ır	IIIN 0 6 2012 August B. 40	are				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 Per FH G928 6/29/2012 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month₀₅ Physician/ Year Jeanne Κ. Nivens 2012 0138 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Montgomery Rockville 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Days Hours 195-28-9119 Country) York **Director** 75 1 □ M 2 🗓 F Usual Residence of Decedent 10-02-1936 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 X Yes 2 No Florida Tampa Hillsborough 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be items 23a Funeral 19117 Lake Audobon Drive 33647 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ö δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 'natural", 3 Widowed 4 Divorced Specify White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Registered Nurse Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles F. Krauser Marguerite O'Connor other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Jeffrey A. Nivens Son 713 Fish Lips Lane, Ruskin, Fl. 33570 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 L Cremation 3 Removal from State National Crematory ,2012 June Falls Church, Va. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Son wice Licens 22. Name and Address of Facility Danzansky-Goldberg Kurt Blake 1170 Rockville Pike, Rockville, Maryland 20852 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Mys cardial disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner mittal Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events or Attending Physician: The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of) resulting in death) Last Physician/Medical aceide berb Division of Vital Records, P.O. Box 68760 as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: use 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an 24b. was an autopsy performed?
Yes 2 No certificate 1 Yes 2 No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Other: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this the funeral Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury hours after death. Ineral Director: A 2 Accident
3 Suicide Investigation 6 Could not be filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completely (Check only one) 29b. Signature and title of certificany

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vinu Gonti MD

19529 Doctors Drive,

32. Registrar's signature

29c. License number

1741162

Germantrun

29d. Date signed (Month, Day, Year)

20874

Mom lond

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 Z:00PM Medical 4a. Facility Name (if not institution, give street and number) County of Death **Examiner** 4b. City, Town, or Location of Death Prince GOVGU 7. Age (In yrs. last birthday) If Under 1 9. Birthplace State or Foreign If Under 24 Hrs. 8. Date of Birth **Funeral** Hours Min. (Month, Day, Year) 72 110-30-2471 CA Director 1 □ M 2 🛛 F Usual Residence of Decedent 12/22/1938 or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Howard MD 1 Tes 2 No Ellicott City 10e, Street and Number 10f. Zip Code 9 10g. Citizen of What Country? ms 23a or Funeral 21042 5320 Dorsey Hall Dr #226 USA items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or iten edical Examiner r was Decedent Ever Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3X Widowed 4 ☐ Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. d other than " event, the Me life. DO NOT use retired) within 7 Elementary/Secondary (0-12) College (1-4 or 5+) Bartender Restaurant 12 event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည pe Emil Gust Oslund traumatic Jean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trai Jeffrey E Oslund Son 5320 Dorsey Hall Dr #226 Ellicott City MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crem 6/1/12 Glen Burnie MD 22. Name and Address of Facility Simplicity Crem & Fun Serv of Funeral Service Licens nony ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Complete Heart Bloc disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Myocardia Intarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine for use as the burial-transi cronary Artery Disease and Due to (or as a consequence of) nding physiciar Physician/Medical The law requires that the death certificate be Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death
Unknown 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) atter Day Month Year signed by the at Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Chronic Obstructive Pulmonary Disease Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Atrial Fibrillation 24a. Was an page 2 autopsy After this certificate has Parkinsons Disease Yes 2 No **Division of Vital** 9 Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 Yes 2 No ည 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural Accident injury 5 Pending Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

within 2 ٥ Registrar

DHMH 17 Rev 06-2011

State

Medical

29a. Certifier

(Check

only one) 29b. Signature and title of certifier

3 [

Physician

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shanmugan

💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

aurel Regional Hospital

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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29d. Date signed (Month, Day, Year)

7300 Van Dusen Road

27/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^D2012 6:35 A. M Jasper William Petrillo June 1, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 6349 Mallard Lane Lothian . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Day Year) 1934 Days Hours April Maryland 1 🛣 M 2 🗆 F Director 579-44-9402 78 Usual Residence of Deceden 28a-f shov 10a. State 10b. Count 10c. City, Town or Location at 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified MD Anne Arundel Lothian 1 X Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20711 United States 6349 Mallard Lane death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, med Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give 1955–1960 Year or Dates. within 72 hours after Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: "natural" Completed 3 Divorced 4 Divorced Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Automotive Mechanic Be fled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Marion Beaver Joseph A. Petrillo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once, Roberta Nappi Petrillo/Wife 6349 Mallard Lane, Lothian, MD 20711 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 2 1 Burial 2 🙀 Cremation 3 🗆 Removal from State Woodbine, MD 4 Donation 5 Other (Specify) Final Journey Crematory 2012 22. Name and Address of Facility Rendon-Hale Lanham Funeral Home of Fur eral S / Ice Lic Insee /M00969 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Year et and Death Immediate Cause (Final Physician) disease or condition resulting in death) Chronic Kidney Disease Medical Due to (or as a consequence of) **Examiner** Year Cerebral Vascular Disease Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury Due to (or as a ponsequence of 10 Years Hospital or Attending Physician: The law requires that the death certificate be executed Hypertension the burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown page 2 should 24b. Were autopsy findings available 24a. Was an has autonsy prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2 V No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2X No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No Natural 5 Pending s after death. Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completely filled in by 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number D45835 June 1, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10845 Town Center Blvd. Suite 203 Catherine I. Brophy, M.D. Dunkirk, MD 20754 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar

JUN 0 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Poe Month Veal hilip 10:12 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard County Columbia, General Hospital Howard Maryland | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | Months | Days | Hours | Min. | Sept. 19 Social Security Number g. Birthplace (State or Foreign Country) Maryland Funeral 7. Age (In vrs. last birthday) 1 🔀 M 2 🗆 F 1940 Director 218-38-6573 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes ŽXX No MD Howard Laurel 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 10686 Old Bond Mill Road 20723 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 X Married Completed by 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 9th Ø HVAC Technician Heating & Air Condition Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Poe Margaret Robey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Jane Poe/Wife 10686 Old Bond Mill Road, Laurel, MD 20723 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important: If it
any injury or or cemetery, crematory or other place 1 XBurial 2 Cremation 3 Removal from State Emmanuel Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 6/5/2012 Laurel, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Retween Immediate Cause (Final Onset and Death Physician Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner adiation weeks Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Small To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cell attending physician and Due to (or as a consequence of): Physician/Medical months Valmous Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Dav Pregnant at time of death 1 Yes 2 g Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Neutropenic 1 Yes 2 No 3 Probably 4 Unknown Completed Delirium 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director, After this certificate homoleted filled in by the funeral director, page COPD 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural 5 Pending iniury Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD- Intensivist Dook 2273 31 2012

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DHMH 17 Rev 7/2009

Registrar

Howard County General Hospital 5755 Cedar Lone, Columbia, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Amin

Shahriar

31. Date filed (Month) Day, Year)

21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 7:27 PM Brandon Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Medical Battimore Center If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min Director 1 **x** M 2 □ F 218-15-9355 34 September 12, 1977 Maryland Usual Residence of Deceden 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director must be notified 1 Yes 2X No Anne Arundel <u>Maryland</u> Severn 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a 787 Stevenson Road 21144 United States death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Was Decedent Ever in U.S. Armed Forces? the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. 2 😾 No 1 Yes 2 No Specify: 3 ☐ Widowed 4 🙀 Divorced Specify. White Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Welder Construction 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ James Edwin Pyles Mary Nicholson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Pyles/Mother Stevenson Road, Severn, Maryland 21144 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, West Arundel Crematory 1 🗆 Burial 2 🕱 Cremation 3 🗆 Removal from State June 4, 4 ☐ Donation 5 ☐ Other (Specify) 2012 Odenton, Maryland f Fundal Service Lic Insee ^{22. Name and Address of Facility} Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 MO1386 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part 1. Exter the shock, or heart Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Diobe CDV disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) use as the burial-transi and Due to (or as a consequence of) attending physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death 5 Other (specify) signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has completely filled in by the funeral director, page 2 autopsy performed Yes 2 After this certificate 2 🗌 No 1 Yes Division of Vital the Hospital or Attending Physician: in 24 hours after death.

the Funeral Director; After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 🗌 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred 5 Pending injury 1 Natural Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one certifie 29c. License number 29d. Date signed (Month, Day, Year) NPI 109303055 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Quartucci 2120 Michael Baltimore MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 0 6 Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend #20b&c Per FH G928 6/08/2012 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4:04 0 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death County of Death Montgomer Washington Adventist Hospita 9. Birthplace (State of Foreign Country) Massachusetts 5. Social Security Number 8. Date of Birth __(Month, Day, If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 🗆 F Months Days Min. Hours 34-24-8668 Director 6 Usual Residence of Decedent Show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho: amy injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Maryland 1 🗌 Yes 2 🗷 No Georges tsv1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? `a 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠ Yes 2 □ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ agins 19a. Informant's Name/Relationship (Type, Print) Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City of Forte POA Friend Drive Maryland 20745 e Oak Oxon Hill 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 6/13/a2012 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ington, Service Signature of Funeral Service Licenses Funeral Chinn 22. Name and Address of Facility obert 2605 S. Shirlington Arlington, Va ead 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SEVERE SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** MESENTERIL 15CHEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year 4 ☐ Pregnant at time of death g ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by END STAGE RENAL DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CARDIO MYOPATHY 24b. Were autopsy findings available prior to completion of cause of 24a. Was an sate has l page 2 s autopsy death? certificate 1 ☐ Yes 2 ☐ No Yes 2 W 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funeral 28d. Describe how injury occurred 1 Natural 5 \square Pending work?
1 Yes 2 No injury ☐ Acciden
☐ Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 22 Evica MD MAY 30th 2012 D 68005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JENNIFER OBIADI, MD 7600 CARROLL AVENUE TAKOMA PARK 20912 Gm 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

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			State Registrar				cate of l			Reg. No		2 1/898		
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and the same of th	Examin		4a. Facility Name (if not institution, give street and number) 33 BURR HILL DRIVE				City, Town, o	r Location of Dea	th	4c. County of Death . WORCESTER				
4	Funeral Director			7. Age	(In yrs. last bi		Under 1 Year nths Days	If Under 24 Hr Hours Mir			g. Bi	rthplace (State or Foreign nuntry) New York		
	death with the Maryland items 23a or 28a-f show ner must be notified at	ector	Usual Residence of Decedent 10a. State 10b. County MD Worcest		10c. City, Tov	wn or Locatio	n	Berlin			-	10d. Inside City Limits		
	the Ma a or 28 be noti	Funeral Director	10e. Street and Number							10g. Citizen of What Country?				
	n with	ners	33 Burr Hill Drive					21811			US	A		
36		by Fu	11. Marital Status 1 □ Never Married	Was Decedent Ev Armed Forces? 1X☐ Yes 2 ☐ N If Yes, Give	o Army		Decedent of F , specify Cuba Yes X No		Specify Yes or No rto Rican, etc.)	-	14. Race - Am Black, Whi	te, etc.		
ି <i>ଶ</i> ଞ	nours latura ical E	lete	15. Decedent's Educa	Year or Dates. 19		a. Decedent's	Usual Occur	pation		16b l	Kind of Busines	White		
21215-0036	should be filed within 72 hours after and Mental Hygiene. is marked other than "natural", or aumatic event, the Medical Exami	Completed by		(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) (Give kind of work done during most of working life. DO NOT use retired)							Local Government			
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obest altimore,	permit. Page 1 and 2 s Department of Health Important: If item 27 any injury or other tr.		20a. Method of Disposition 1 ☐ Burial ※☐ Cremation 3 ☐ Rer	moval from State	20b. Place cemet	of Disposition	(Name of y or other pla	ce)	Date	20c. L	_ocation - City c	r Town, State		
Similar Timing	Page tment tant: I jury o		4 ☐ Donation 5 ☐ Other (Specify)	noval from State	1	sapeake (26/2012		Beltsvil	le, MD		
Ball	permit Depar Impor any in	6	21. Signature of Funeral Service Licensee	1 100	ميلام	11	ne and Addre		nvisos DO I	Day 1/	112 Daltim	oro MD 21202		
`			Dorota Marshall 23a. Part 1. Enter the disease, or complica	tions that caused t	the death. Do						+13 Daitiiii	ore, MD 21203 Approximate		
1)	Ph_sician/	2	shock, or heart failure. List only one c Immediate Cause (Final disease or condition	ause on each line.	NAN	T 57	OMAC	H CA	RCINO	ard		Interval Between Onset and Death		
	Medical Examiner		resulting in death)	Due to (or as a c		e of):				-/				
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Вох	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	onths?							23d. Date of d Month	elivery Day Year		
P.O.	that the ined by the deta	by PI	Part II. Other significant conditions contri	ons contributing to death but not resulting in the underlying cause given in Part I.								e to the cause of death?		
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<u>~</u>	ysician: The Is s certificate ha director, page	Be C	25. Was case referred to medical				26. P	lace of Death (Ch	1 \(\supersection \) Yes	PLIN	1	es 2/ No		
Zit.	ysicis is cert direct	To B	examiner? 1 Yes No	pital:	nt 2 🗆 ER/0	Outpatient 3	Oth	er.	Home 5 Res	idence	6 Other (Spe	cify)		
1 of	ing Ph		27. Manner of Death 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	28a. Date of injury (Month, Day,		. Time of injury	28c. Injur	k?	28d. Describe	how inju	ry occurred			
Division of Vital Records,	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certificate:	2 ☐ Accident Investigation	28e. Place of Injury building, etc.		farm, street, f		Yes 2 □ No	28f. Location City or To			ural Route Number,		
	e Hospita 24 hours e Funeral eletely filled	Medical	29a. Certifier (Check 2 Medical Examiner:	On the basis of exa	amination and	or investigati-	on, in my opini	on, death occurre	d at the time, date	and plac	e, and due to the	cause(s) and manner stated.		
	To the within 2 To the Comple	2	29b. Signature and title of certifier			J-, 4-94								
	ax'		30. Name and address of person who comp	oleted cause of dea	ath (Item 23a)	(Type, Print)	1733	SAC	is Bu	iso	w	11/802		
	State		31. Date filed (Month, Day, Year)	32. Registrar	's Signature		,		- 0	-/-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death

436 PM Physician/ Mai SICE Zol ODNE Medical 4a. Facility Name (if not institution, giv 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Randallstown Northwest Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 214-56-0766 08/10/1950 **Director** 1**X** M 2 □ F 61 Yrs Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at **Funeral Director** Brooklyn MD 1 Yes 2 X No 10f. Zip Code 0 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a 21225 USA 602 Hammonds Lane Apt 315 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No
If Yes, Give Viet Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify Viet Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Self-employed Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked o ပ Lenora Parker Jacob L Price permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 602 Hammonds LN Apt 315 Brooklyn MD 21225 Wife Edna P. Price 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 XCremation 3 ☐ Removal from State Glen Burnie MD 6/1/2012 Atlantic Crem 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licer 22. Name and Address of Facility Simplicity Crem & Fun Serv Thomas Allen PA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 hknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 No 1 🗌 Yes Yes 2 Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Pother 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes Investigation Accident 24 hours after deatle Funeral Director. 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one) 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) GAHON

DHMH 17 Rev 06-2011

State

Registrar

JUN 0 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 8,20b,24a per fh/verb., g928,06/06/2012dhb,30 Certificate of Death Reg. No. Registra Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2017 6: Medical 4a. Facility Name (if not institution, give street and number, or Location of Death **Examiner** evindale Hebrew Genetric Cen 1m01 8. Date of Birth 3/16/1921 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) ear If Under 24 Hrs. If Under **Funeral** 1 M 2 □ F 91 Hours Marviland Director Usual Residence of Decedent or items 23a or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 🛚 No Maryland Anne Arundel Arnold 10f. Zip Code 10g. Citizen of What Country? Funeral 190 Campus Green Road 21012 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 A Yes 2 If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) John Hopkins Elementary/Seconday (0-12) College (1-4 or 5+) Machinist Applied Physics Lab Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Rush Cunigunda Alp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8365 Lockwood Road, Pasadena, Maryland Jason M. Rush:Son Department of Healt Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ardent Cremation, Inc. 05/15/2012 20a. Method of Disposition 20c. Location - City or Town, State 1 D Burial 2 X Cremation 3 D Removal from State Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009 Harford Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ischemi Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Saquentially flet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? M Natural injury 5 Pending 2 🗌 No death. Accident Investigation after death ☐ Accider☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check within 2 To the 6 only one) 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

acked

Baltimore, MD 21215

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Levindale Hebrew Geriatric Center 2434 W. Belvedere Ave.,

Registrar's Signature

Levindale Hebrew

JUN 0 6 2012

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend Item 29d per np, g928,06/06/2012dhb
Registrar Certificate of Death
Reg. No. 2 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05 Helen Rosenberg 2012 7:25 Α Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery Social Security Number 7. Age (In vrs. last hirthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Min. (Month, Day, Year) 07/31/1923 1 🗆 M 2 🗀 F New York **Director** 119-18-6965 88 28a-f ahow 10a, State 10b County within 72 hours after daath with the Maryland th and Mantal Hygiana. 27 is marked other than "natural", or itema 23a or 28a-f aho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director X□ Yes 2 □ No MD Montgomery Montgomery Village 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18700 Walkers Choice Road, #801 20886 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces ģ 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 ☐ Divorced Specify. Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 4 Librarian Service Be 17. Father's Name (First, Middle, Last) amit. Page 1 and 2 should ba filar apartment of Haatth and Mantal H iportant: if Item 27 is marked oth iy injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ည Murray Greenbaum Rose Burner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jill Filler / Daughter 19001 Stedwick Drive, Montgomery Village, MD 20886 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dapartmant of Important: If it any injury or o 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 5/25/2012 Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Vulvar Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury Due to (or as a consequence of). attanding physician and I for usa as tha burial-transit Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death Day Year signad by tha at d ba datachad f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> cate has baen siç : paga 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No After this certificate funaral diractor, pag 1 ☐ Yes 2 ☐ No 25. Was case referred, to medical 品 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 🗹 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After th compliataly filled in by the funera 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of erai Director: After fillad In by tha funar 28c. Injury at 28d. Describe how injury occurred 1 2 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be

Division of Vital Records, P.O. Box 68760

DHMH 17 Rev 06-2011

State

Registrar

Medical

4 Homicide

29a. Certifier

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only one 29b. Signat

Debrah

31. Date filed (Month, Day,

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JUN 0 6

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ller

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 💢 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Muhaster kill

R143201

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

6001

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) 05/23/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Shariff Ruffin 7:10 PM une 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPITAL OFBALTIMORE BALTIMORE . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Months Days Hours Min. (Month, Day, Year) 03/16/85 215-08-6813 Director Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director Maryland Waldorf 1 Yes 2X No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 3143 Sedgewick Drive 20603 USA death v 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates Specify: Black "natural", Completed 3 Widowed 4 Divorced Il Hygiene.

other than "natura 16b. Kind of Business Industry Special 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Events Med.Services Elementary/Seconday (0-12) College (1-4 or 5+) Emergency Medical Tech. year other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisherships is marked of Thomas Ruffin Katherine Dawson permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joslyn Peters/Sister 3143 Sedgewick Drive Waldorf MD.20603 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 06/08/12 Arbutus Maryland 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Mem.Park 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd, Baltimore MD. 21215 Signature Funeral Service License aris 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ metastatic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Completed has been signed to 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performe certificate 2 **X**No Yes B 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 잍 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at ë 28d. Describe how injury occurred Natural injury work 5 Pending Certificat 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation Director; 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined

31. Date filed (Month, Day, State Registrar

. Name and address

Acron Zickerber

29a, Certifier

(Check

only one) Signati

> pleted cause of death (Item 23a) (Type, Print SMAH HOSPITES Registrar's

MI

Baltimore, Maryland 21218

29d. Date signed (Month, Day, Year)

June 2 2012

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D38-12-7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Y Blanche Robinson 5: 25A M 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Milford Manor Baltimore Pikesville If Under 1 Year | If Under 24 Hrs.

Months Davs Hours Min. 9. Birthplace (State or Foreign Country) North 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 243-26-1387 **Director** 1 □ M 2 🖺 F 93 09/01/1918 Carolina Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location at 10d. Inside City Limits Director or 28a-f sl Baltimore Maryland 1 X Yes 2 ☐ No 123a c. tbe n∕ 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21215 6606 Park Heights Avenue must USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Examiner Armed Force or. þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify. "natural", 3 N Widowed 4 Divorced Completed Year or Dates than "natur he Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Balto. (Specify only highest grade completed) City School System Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene. the Cafeteria Manager 11th grade alth and Mental Hygie 27 is marked other Be filed v traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Fletcher Phair Rozena Baldwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosada Thompson/daughter 6606 Park Heights Ave. Baltimore MD. 21215 item 2 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ō = 5 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Department of Important: If any injury or once, 06/01/12 Arbutus Maryland Arbutus Mem.Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home ulle 5240 Reisterstown Rd. Baltimore MD.21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final BREAST Physician CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Dav Year Pregnant at time of death g Unknown Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown plnous Were autopsy findings available 24a. Was an page 2 After this certificate has prior to completion of cause of death? autopsy 2 🗌 No 1 Yes To the Hospital or Attending Physician: i within 24 hours after death.

To the Funeral Director: After this certifica filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Yes 2 No 1 Natural 5 Pending injury 2 Accident
3 Suic Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deam occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 29b. Signature and title of certific 29d. Date signed (Month, Day, Year)

State Registrar M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LEUNARD RICHARDSON

PS7722

1838 GREENE TREE ROAD #300 PIKETUILLE MA 21208

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Joseph Eugene Francis Ruff Month O G Physician/ PM 1:05 Medical Facility Name (if not institution, give street and number 4c. County of Death **Examiner** Hospice WICOM 7. Age (In vrs. last birthday If Unde 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Country) Maryland Months 76 1 ₹ M 2 □ F Aug 15, **Director** 28a-f shov 10b. County permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Worcester Berlin 1 Tes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21811 8529 North Longboat Way USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Joseph Puff Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕱 No Specify Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Dundalk Marine Terminal Longshoreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Mary Conway မ Lawrence Ruff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1420 Towson St.. Baltimore, Maryland 21230 19a. Informant's Name/Relationship (Type, Print) Peggy A. Ruff-Purnell (Daughter) 1420 Towson St., Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar HIII Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 6/7/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee KLVIN L Fcker McCully-Folyniak Funeral Home, P.A. 22. Name and Address of Facility 130 East Fort Ave., M00175 Baltimore, Maryland 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician) ASCVD disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine Dise to for as a consequence off cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 ☐ Ectopic pregna5 ☐ Other (specify) in the past 12 months? Month Day Pregnant at time of death 2 No the should be detacl signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed Yes 2 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural Natural 5 Pending work? 1 Tyes 2 🗌 No 24 hours after death Funeral Director: A Accident completely filled in by the Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 | within 2 To the F Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D 63199 6/2/12 ddress of person who completed cause of death (Item 23a) (Type, Print)

NO HRA 910 EASTOLN SHORE DR, SALISBURY, MD, Name and 32. Registrate Signature 31. Date filed (Month, Day, Year) JUN 0 6 2012 State Registrar

Please Type or Print in Black Indelible Ink. Fasure All Copies Are Legible.

AMEND ITEM#30 per DVR. 6928, 676, 72012, will Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Beg. No. 2012 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Menth 6 2012 2:55 Рм Nadine Shiela Rubenstein Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 303 Elm Avenue Takoma Park Montgomery Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours **Director** 144-48-2083 1 □ M 2 😿 F 10-27-1953 58 New Jersey Usual Residence of Decedent 28a-f show 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Takoma Park 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20912 303 Elm Avenue United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2X No Black, White, etc. b 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Doris Lebwohl Rubenstein Joseph Rubenstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Adele R. Josovitz - Sister 126 Rosemere Avenue, Fairfield, CT 06825 Department of Health Important: If item 27 any injury or other th once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Perrineville Cemetery 6-4-2012 4 ☐ Donation 5 ☐ Other (Specify) Perrineville, NJ 21. Signature of Funeral Service Licenses Brian Deibler 22. Name and Address of Facility Danzansky-Goldberg 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year signed by the a 1 Yes 21 9 Unknown P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? AUTDIMMUNE Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy page performed? Yes 2 No 1 Yes 2 No Division of Vital To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 \(\sum \) Yes Hospital: 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) s after death. Certificate; 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a

To the Funeral I

completely filled Hospital Medical Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation in the first state. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DO0649 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Silver Spring, MD 20902 Kashif Firozvi 2101 Medical Pk. Dr. 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. AMEND ITEM#19b, perFH, G928, 6/6/2012, WS State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Jacqueline Lola Roberts June 5 2012 6:33 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Carroll Hospital Center Westminster Carrol1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Min (Month, Day, Year) 326-24-9924 1 □ M 2 XX **Director** Yrs. 81 Mar. 26, 1931 Illinois Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? mit. Page 1 and 2 should be filed within 72 hours after death with the astiment of Health and Mental Hygiene. ortants if item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be. Funeral 205 Northway Road U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1XXNever Married 2 Married Black, White, etc. þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes, Give Year or Dates Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Teacher/Guidance Counselor Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Thomas Roberts Agnes Gnass 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Eural Poute Number City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Joan C. Stall (Friend) 205 Northway Rd., Resiterstown, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) XX Burial 2 Cremation 3 Removal from State 6/11/2012 4 Donation 5 Done (Specify) Cedar Park Cem. Calumet Park, IL nature f Funeyal Sonic dicenses 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd., Owings Mills, MD 21117 1. Inter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Atheroscheichie Comminy Viscole Oisant Immediate Cause (Final Onset and Death Physician/ disease or condition Y/1 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): iding physician Physician/Medical Box 68760 use as the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Ferance...

Pregnant at time of death in the past 12 months?

1 Yes 2 No
9 Unknown jo Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? Yes 2 this certificate 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Registrar

31. Date filed (Month, Day, Year) JUN 0 6 2012

29b. Signature and title of certifier

only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Moss 114 Brands Center Dave Renter And M.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

6/05/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death

F	Physicia Medio											June Oziaoja 1835					
	Examin		4a. Facility Name (if not institution, give st		4b. City, Town, or Location of Death					h 4c. County of Death							
· .			Brocke Grove Rehabili					Sandi		pring			lontqu	mer	4		
	Funeral Director		5. Social Security Number 6. Sex 404-40-1379	7. Age	e (In yrs. las 78	ast birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.					8. Date of Birt	22	Birthplace (State or For Country)				
			Usual Residence of Decedent		70		·-				12/11	./19	33		" KY		
and	shov 1 at	ō	10a. State 10b. County		10c. City,	Town or	Locat	tion						10	d. Inside (City Limits	
Aaryla	8a-f tiffied	rect	MD Montgome	rv		01n	ev								1 □ Y€	es 2 🔀 No	
the A	or 2	اقا	10e. Street and Number 10f. Zip Code								Т	10g. C	itizen of Wha	at Countr	y?		
with	s 23s ust b	Funeral Director	18201 Slade School Rd. 20832										USA				
death	item ier m						I3. Wa	s Decedent of Hi	spanic Orig	gin? (Spec	cify Yes or No-		14. Race -				
36 affer o	", or tamir	by	1 Never Married 2 Married 1 Yes 2 🖾 No					If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🎛 No Specify:						White, et	C.		
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Maryland 21215-0036 2 should be filed within 72 hours after death with the Maryland	n of near an unwinten rygene. The man is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at.	ပ္ပြဲ	Elementary/Seconday (0-12)	College (1-4 or 5+)			life. DO NOT use retired) Homemaker					н	er Hon	nΔ			
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re, Maryland	27 i		Michael Rodgers/	Son				Ridge 1						, ,			
ore,	item		20a. Method of Disposition		20b. Pla	ace of Dis	sposit	ion (Name of			ate		ocation - Cit	ty or Tow	n, State		
Page 1	Department of Important: If any injury or once.		1 ☐ Burial 2 🛣 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		-		ory or other place. 1 Crema		6/5/	2012	Wi	nfield	1. МІ)		
Baltimore,			21. Signature of Funeral Service License	7				ame and Addres								Δ	
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Box 68760 death certificate b	phys the	sician/Medical	d														
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	After this certifica funeral director, p	jë	27. Manner of Death 1 Natural 5 Pending	28a. Date of injur (Month, Day,	y Year) 2	8b. Time injury		28c. Injury work?	at	28	8d. Describe h	ow injur	y occurred				
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DIVISION OF VITAI RECORDS, tal or Attending Physician: The law requires after death.	Direction by	Certificate:	4 Homicide determined	28e, Place of Injui building, etc.		ie, farm,	street,	factory, office		2	8f. Location (S: City or Town			r Rural Re	oute Numi	ber,	
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DIVISION OF VITAL To the Hospital or Attending Physician: within 24 hours after death.	To the Funeral Director: completed filled in by the		only one) 3 L Certifying Nurse 29b. Signature and title of certifier	ractioner, to the t	JOSE OF THY F	a rowledg	e, uea	29c. License		ши рысе			s) and manne te signed (M				
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	/	ŀ	30. Name and address of person who con		ath (Item 2	3a) (Type	e, Print	t)					11 0,				
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State

Registrar

31. Date filed (Month, Day, Year)

JUN 0 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Robert RUSSELl Year **Physician** A 8:11 lune 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min Director 214-22-5324 2-19-1927 MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 □ No Director MD BALTIMORE 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country Funeral 4409 ANNTANA AVENUE 21206 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ 3 Widowed 4 Divorced Specify: WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) SHIPPING MANAGER PRINTING 12TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ WILLIAM RUSSELL HELEN BROUGHTON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY RUSSELL **SPOUSE** 4409 ANNTANA AVENUE BALTIMORE, MD. 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) GARDENS OF FAITH 6-5-2012 BALTIMODE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC e 6415 BELAIR ROAD BALTO. MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASCVD Years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Examine Due to (or as a consequence of): The law requires that the death certificate be executed physician and as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) d by the at detached f 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ ate has been sig page 2 should b 2 No 3 Probably 4 Hnknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 1 certificate 1 Yes or Attending Physician: 25. Was case referred to medical examiner?

Yes 2 □ No Be 26. Place of Death (Check only on Hospital: 1 Inpatient Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) ပ ER/Outpatient 3 DOA this completely filled in by the funeral Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred Natural 5 Pending investigation Injury 1 🗌 Yes 2 ∏ No 2 Accident s after death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 24 hours a Hospital 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

11595

within 2 To the I

29b. Signature and title of certifier

Shavon Bord

31. Date filed (Month, Day, Year)

JUN 0 6 2012

Registrar DHMH 17 Rev 1/2001

State

parker

29c. License number

D67067

29d. Date signed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

2012

and manner stated.

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death RAL KODPENZ Physician/ Month 30 A M 5 Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TOHUS HOPHINS CARE (ENTE るんしてしいので BALTIMORE CIT Social Security Number **Funeral** 6 Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 D F Months Days Hours Min Director 214-30-5767 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits ems 23a or 28a-f sh must be notified a MD N/ABaltimore 1 ¥ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21224 U.S.A. 5505 Hopkins Bayview ral", or items? death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 ☐ Yes 2X No Specify: If Yes, Give Specify: Black "natural" 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) N/A Laborer 12th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Department of Heath and Mente Important if item 27 is marked any injury or other traumatic once. Unk Lonnie Ray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Minton(sister) 3476 Dolfield Ave., Baltimore, MD 21215 timore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗀 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) on-site Crematory 6-4-/2 |Baltimore,MD 21. Signature of Funeral Service Licensee ජීඵ්ප්ප්රේති of Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore,MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PAILME Immediate Cause (Final rende Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner DIANE Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events CENSION Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Pregnant at time of death Month Dav Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas performed' After this certificate Yes 2 L director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2. No Other: မြ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending s after deau. 1 Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAYLION CK. BACTIMENE MY SLISSEL ð 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND FITEM#10d, 13, per FH, G928, 6/8/2012, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month $20\overset{\text{Year}}{12}$ 2, 4:31 P M Prabhas Chandra Sharma June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis 8. Date of Birth (Month, Day, Ye April 16, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 🙀 M 2 🗆 F Months Days Hours Min. Year) Country) India **Director** 1940 577-78-1346 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director TA Yes 2X No Maryland | Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20720 11108 Fruitwood Drive within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 Yes 2 No If Yes, Give Year or Dates Specify: Asian Indian Specify. 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Government Contracting Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Kundan Lal Shastri Draupadi Sharma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) I and 2 s i Health a Bowie, Maryland 20720 Akash Kaushik/Son 12718 My Mollies Prid Drive, 20b. Place of Disposition (Name of cemetery, crematory or other place)
West Arundel Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date Department of I Important: If ite Page 1 June 5, injury or 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2012 Odenton, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 M01386 23a. Part 1. Enter the disease, or complications that caused the death. Domonenter the mode of dying, such as cardiac or respiratory arrest, shock, or heart railure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin requires that the death certificate be executed Cause (Disease or linjury that initiated events sician and burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 the L iding p IE EEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? ģ Month Day Year 2 🗌 No ed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No Yes 2 4 Vital 25. Was case referred to medical examiner? Hospital or Attending Physician: 26. Place of Death (Check only one) Be Hospital Other: 2 No 1 Yes ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, Division of 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) □Natural injury 5 Pending n 24 hours after death.

The Funeral Director: After the full of t 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier Certifying Physjeian: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the within 2 To the F Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one CC38445 29b. Signatu 06/ 2012 VI 30. Name and pleted cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend 19a, per fh, g928 6-25-12 sm State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 2149 Frieda Molly Sobell Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Min. Hours Director 88 1 🗆 M 2 🗓 F 106-18-4943 12-4-1923 New York Usual Residence of Deced or items 23a or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at **Funeral Director** Rockville MD Montgomery 1 🗌 Yes 2 🗓 No 10f. Zip Code 10g. Citizen of What Country? 1801 E. Jefferson Street #629 20852 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Phillip Nissenbaum Albina Zucker 19a. Informant's Name/Relationship (Type, Print)
Szymanski
Lisa Szymanski – Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8607 Coral Gables Ln., Vienna, Virginia 22182 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ò 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 6-4-2012 4 ☐ Donation 5 ☐ Other (Specify) Mt. Lebanon Cem. Adelphi, Maryland 21. Signature of Funeral Service Licensee Edward Sage1 22. Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike, Rockville, Maryland 20852 te 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Atherosclerotic Cardiovascular Disease disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 1 Yes 2 9 Unknown the a 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cardiomyopathy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv 2 X No 1 ☐ Yes 2 ☐ No Yes Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 🗓 DOA Other: 은 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work? 1 Pyes 2 No 5 Pending Accident Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours Medical 29a. Certifier 1💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 06-01-2012 D3027 O_{\prime} 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul O'Brien, MD 8600 Old Georgetown Rd., Bethesda, Maryland 20814 32. Registrar's Signature State 2012 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 2, 4:05P **THERESA** WOODHAM **SWARTZ** 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3100 Sunset Lane Phoenix Baltimore 6. Sex Social Security Numbe 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours (Month, Day, Year) 1 ☐ M 2**X X**F **Director** 265-42-0093 79 08-03-1932 Florida Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified 1 Yes 2 X No |Maryland| Baltimore Phoenix 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe or must be Funeral |3100 Sunset Lane 21131 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Korea
If Yes, Give
Year or Dates. Black, White, etc. "natural", or it edical Examine by 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify. 3 ¥ Widowed 4 □ Divorced Completed White Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Private School Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Esker Woodham Nellie Pearl Donaldson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3100 Sunset LAne Phoenix, Maryland21131 Theresa Marie Swartz DTR 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial XX Cremation 3 ☐ Removal from State GreenMount Crematory 06/08/2012 Baltimore, Maryland Donation 5 Other (Specify) Signature of Funeral St 22. Name and Address of FaMilytchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death toucur Physician/ disease or condition Medical resulting in death) Lateral Sulerosis mentes **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) for in the past 12 months? Pregnant at time of death Month Day Year ped 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has b autopsy performe ∐ Yes 2 💢 1 Yes 2 No Hospital or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home 5} \) Residence 6 \(\text{Other (Specify)} \) 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury_at 1 Natural 5 Pending Investigation work?
1 Yes 2 No Accident 24 hours after death Funeral Director: Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D32453 6/2/12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark LAmos MD 9 Shilling Road Hunt Valley Maryland 21031 Suite 102

31. Date filed (Month, Day, Year) State JUN 0 6 2012 Registrar

32. Registrar's Signatu

VOID

CERTIFICATE

2012-17913

SEE

CERTIFICATE

2012-17178

Calvinspe 12-04056 UNK UNK		State of Maryland / Department of Health and Mental		gible. 20 i	2 1791
		1- For State Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Dea	eg. No.	3. Time of Death
Physician Medical Examin	14	CALVIN SPENCER	Month May 28, 2	Day Year 012	2346 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dec	ath	4c. County of Deat	
		Prince George's Hospital Center Cheverly 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24h	dro 18 Date of Bir	Prince Georg	
Funeral Director			nin. 10/06/	Forei	gn puntry)GEORGIA
0 1	ŀ	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
and show	۱.	GA STEVENS TOCCOA			1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once	Director	10e, Street and Number 10f. Zip Code	1	0g. Citizen of What Cou	
th the notific		1061 HENRY WILLIAMS ROAD 30577 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Vac or No	UNITED S	TATES
items	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Pue		White, etc.	jour main, black,
fter de	و بر	1 X Yes 2 No No No No No No No		Specify: BL	ACK
nours a		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use recommendation)		16b. Kind of Business	Industry
36 in 72 h	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 2 YRS MECHANIC		PRIVA	тғ
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	탉		me (First, Middle, I		-
213 be fill rked	Be	ROBERT SPENCER MARY		CULVER	
D 21 should and Me atic co	۱٩	19a. Informant's Name/Relationship (Type, Print) AMETES SPENCER-GATES / DAUGHTER 4421 23RD PARKWAY #T-		· ·	
, MD and 2 sho ealth and rem 27 is	ŀ	AMETES SPENCER-GATES / DAUGHTER 4421 23RD PARKWAY #T- 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or	
Ore ges la rt of H rt of H		1 Burial 2 Cremation 3 Removal from State crematory or other place)	01/2012	DIVEDDALE	MADNIAND
Baltimore, permit. Pages 1 ar Department of He. Important: If ite	ŀ	4 Donation 5 Other Specify: RIVERDALE CREMATORY 6/ 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.	01/2012 B JENKINS	RIVERDALE,	OME, INC.
Dep Depri	-	Normal N. Cornalius 7474 LANDOVER ROLL	AD, HYATT	SVILLE, MA	
Physician Me dit		23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial failure. List only one cause on each line.	c or respiratory am	est, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrhythmia Due to (or as a consequence of):			Death
	-	Sequentially list conditions. b. Tunnel Coronary Artery			
	aminer	if any, leading to immediate Due to (or as a consequence of):			
- LA		(Disease or injury that initiated events resulting in death) Last Use to (or as a consequence of):			
/D g a E	편 교	d. ☐ AMENDED 23a-b,pt.II,27,per me,g930 8-	0_12 cm		
50, te be e: ysiciai	ğ	■ MENDED 23a-b,pt.II,27,per me,g930 8- IF FEMALE: 23c. If yes, outcome of pregnancy	7 12 311	23d. Date of deliver	
tal Records, P.O. Box 68760, cian: The law requires that the death certificate be excertificate has been signed by the attending physician ector, page 2 should be detached for use as the burial		23b. Was decedent pregnant in the past 12 months?	gnancy		Day Year
eath ce attence for use	Sici	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown		0	
O. But the d		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
, P.O. rres that the signed by be detach	d b	Alcohol Use	1 Yes	s 2 No 3 Pro	bably 4 V Unknown
ords w requires been should	Completed		24a. Was autop	sy prior to	utopsy findings available completion of cause of
Reck The lar cate ha	Ĕ		1 Yes	rmed? death? 2 No 1 ✓ Y	es 2 No
Vital Rec ysician: The his certificate director, page	8	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nur			
f Vil	의	1 ✓ Yes 2 No No No No No No No No No No		Residence 6 Othe	er:
on of nding Pl	<u>ë</u>	1 X Natural 5 Pending (Month, Day, Year) 1 Yes 2 No			
Division of Vital Records, rs for Attending Physician: The law require state death. al Director: After this certificate has been si de in by the finneral director, page 2 should be a seen si de in by the finneral director, page 2 should be a seen si de in by the finneral director, page 2 should be a seen si de in by the finneral director, page 2 should be a seen seen seen seen seen seen seen s	ig E	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.		Street and Number or Ri	ural Route Number, City
Div pital o ours at filled i	Certification:	4 Homicide determined (Specify)	or Town, S	mate)	
	Medical (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a one) 2 V Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred	and due to the caused at the time, date	se(s) and manner as sta and place, and due to the	ted ne cause(s)
To To com	흵	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	
		(and Hellan O.C.M.E.		May 29, 2012	
Ø	ł	30. Name and address of person who completed cause of death (Item 23a) Carol H. Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore	re MD 21223		
Xi./ Sta	te.				
Registr		31. Daty find (Annie Day, Year) 32. Registrar y Signatur			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month xterens Andrew sun 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 9621 Ashlyn Circle Baltimore Owings Mills 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 8. Date of Birth **X** M 2 □ F Months Days Feb. 13, 1931 Pennsylvania Director 207-22-2002 Usual Residence of Decedent d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director Owings Mills 1 ☐ Yes 🏋 No MD Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 9621 Ashlyn Circle 21117 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

TX Yes 2 No if Yes, Give Year or Dates. Korea 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. <u>م</u> 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Bookkeeper Utilities Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Richard T. Stevens Laura Gastrock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Jane Candace Stevens / Wife 9621 Ashlyn Circle Owings Mills, MD 21117 20a. Method of Disposition
1
Burial XX Cremation 3
Removal from State 20b. Place of Disposition (Name of cemetery, grematory or other place)
AII Faiths
Crematory & Chape1 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) June 6,2012 Manchester, MD 21. Signature of F al Se vice Licens 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. thehow 11605 Reisterstown Rd. Owings Mills, MD 21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Henu disease or condition resulting in death) Jorman Boyean Medical Due to (or as a consequence of): Examiner erension ear Sequentially list conditions, if any, isating to minimal attactures. Enter Underlying Cause (Disease or linjury as a co sequence of): attending physician and for use as the burial-transit ridemua ear that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE: es, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy performed Hospital or Attending Physician; The 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospina... within 24 hours after death.
To the Funeral Director: After a funeral filled in by the fur 1 Natural 5 Pending Investigation 6 Could not be 1 Yes 2 No Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0051552 erson who completed cause of death (Item 23a) (Type, Print) Pilcesville, Maryland ree Road

Registrar

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SNEED 2012 5:00 P M May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Forestville Nursing and Rehab Center Forestville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 8. Date of Birth Days Hours (Month, Day, Year) **Director** 578-22-5273 1 X M 2 | F 89 Yrs. 20, 1923 DC Jan. Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. 28a-f show 10a. State 10h Counts 10c. City, Town or Location Director 10d. Inside City Limits notified 1 Yes 2 K No Prince Georges Suitland 10e. Street and Number 10f. Zip Code be 10g, Citizen of What Country? Funeral 20746 USA 6229 Auth Rd. . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, other traumatic event, the Medical Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give WWII
Year or Dates. Black White etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: 3 X Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Computer Technician Dept. of Labor 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Rosie Sneed Zebedee Sneed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Page 1 and 2 sh tment of Health a tant: If item 27 is Suitland, MD 20746 Rosie Sneed - daughter 6229 Auth Td. permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-20-2012 Arlington National Arlington, VA 21. Signature of Funeral Service Licenses Marshall-March Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Errer underlying Cause (Disease or injury Examiner Due to (or as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of): physician Certificate: To Be Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Dav Year Pregnant at time of death the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Division of Vital Records, P.O. Box 68760 n 24 hours after death.

The Funeral Director. After pletely illed in by the fur

within 2

To the I

completed XX

> State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month) Day

3 Certifying Nurse Practitioner: To the bind of my knowledge

Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge seath occurred at the first date and place, and due to the cause(s) and manner as stated.

6134 Aiahon B

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2X F Days 45 212-78-7469 Director June15,1966 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1 X Yes 2 ☐ No Director 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 911 S. Clinton Street 21224 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 💆 No
If Yes, Give
Year or Dates: Black, White, etc. Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Office Manager Elementary/Secondary (0-12) College (1-4 or 5+) CBF Brokerage 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wayne Lee Snyder Sarah Catherine Rolfe ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah Yourik /mother 3108 Elliott Street Baltimore MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Bayview Crematory 6/5/12 4 ☐ Donation / 5 ☐ Other (Specify) Baltimore MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 300 Mace Ave. Balto. MD olui anne Connelly Funeral Home of Essex 1 23a. Part 1. Enter the distase, of the plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List may one cause or each line. Approximate Interval Between Immediate Cause (Final disease or condition **Physician** //Medical resulting in death) Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 4
Pregnant at time of death 2 No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records, 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has b autopsy performed? Yes 2 | No 1 ☐ Yes 2 1 No certificate Division of Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗌 No 1 \square Inpatient 2 ER/Outpatient 3 □ DOA Japita.
4 hours after dea.
5 eral Director: After un.
7 hv the funeral dir ျ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only within 2 To the F the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

11595

State Registrar 31. Date filed (Month, Day, Year) JUN 0 6 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature

10028684

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 1 per dr., g928,06/062012dhb Certificate of Death Reg. No. for State Registrar Decedent's Name (First, Middle, Last) Raymond Slege1 2_Date of Death Physician/ Wonth CL A M Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Seasons Hospice at Northwest Hospital Randallstown Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Pay, Year)
Dec. 18, 1931 9. Birthplace (State or Foreign Country) NJ 7. Age (In yrs. last birthday) **Funeral** 196-24-9864 Dec. Director 1 🗓 M 2 □ F 80 10a, State 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f NC Dare 1 ☐ Yes 🏋 ☐ No Kitty Hawk 10e. Street and Number 10f. Zip Code ō 10g, Citizen of What Country? ms 23a or must be r with 231 Sea Oats Trail 27949 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ▼ Yes 2 □ No
If Yes, Give 105 4 □ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 nan "natural", Medical Exan 1 ☐ Yes 2 X No Specify. White Specify: Completed 3 Divorced 4 Divorced Year or Dates. 1954-58 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) r than ", Computer Science/ Education Elementary/Secondary (0-12) College (1-4 or 5+) Computer Scientist/Mathametician 27 is marked other r traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental မ Raymond Slegel Margaret Geiger 19a. Informant's Name/Relationship (Type, Print) Mrs. Suzanne D. Slegel (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 231 Sea Oats Trail, Kitty Hawk, NC 27949 Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State Forest Lawn Cemetery 05/31/2012 Norfolk, VA 4 Donation 5 Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA MO0764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine cause (Disease or injury that initiated events Due to (or as a consequence of). resulting in death) Last Due to (or as a consequence of) burial-Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ been signed by the atter should be detached for i in the past 12 months? Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manne of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending of the state of th Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

DHMH 17 Rev 06-2011

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Gerard Charles Schultz 06 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6 Sex **Funeral** Days Hours 217-34-9607 Director 1 😿 M 2 🗆 F 09/15/1940 28a-f show 10a, State 10b. County 10c. City. Town or Location must be notified at **Funeral Director** MD Harford Kingsville 10e. Street and Numbe 10f. Zip Code ō 10g. Citizen of What Country? 23a 812 Petem Road "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Army Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify. Completed Specify. 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Med once. than, Elementary/Secondary (0-12) 10th College (1-4 or 5+) Self Employed Ambulance Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Schultz Anna Friedel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Schultz - Wife 812 Petem Rd., Kingsville, MD 21087 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Mem. 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 06/09/2012 Towson, MD 4 Domation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 610 W. MacPhail Rd., Bel Air, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ arrest disease or condition resulting in death) Cardiac Medical **Examiner** Acute myocardial infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last Physician/Medical ivision of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) ____ 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coronary artery disease 1 Yes 2 No 3 Probably 4 Unknown Peripheral vascular disease 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined City or Town, State within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year)

Year

2012

MD

10:28

Birthplace (State or Foreign Country)

White

Approximate Interval Between Onset and Death

2 **1** No

1 Yes

10d. Inside City Limits

1 Yes 2 X No

Registrar DHMH 17 Rev 06-2011

State

completed cause of death (Item 23a) (Type, Print)

1 - For State Registrar Reg. No. Z U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Grace Anna Schellenberger /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner WERSIDE 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Months Days Hours Min. 217-22-0090 1 □ M 2 ⋤ F 99 11/18/1912 Director Usual Residence of Decedent Sthellenberge 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It e Medical Examination to other traumatic event, It e Medical Examination to other traumatic event, It e Medical Examination to other traumatic event, It e Medical Examination to other traumatic event, It e Medical Examination to examinate the content of the content event in the content event events. Belcamp MD Harford Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1123 Belcamp Garth 21017 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify. ≥ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Wire Department Book Bindery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Julia Stitchel Lawrence Goodman 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1603 Redfield Rd. Bel Air, MD 21015 Shirley Lastner- Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith Cem. Date 06/04/2012 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Rosedale, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility SchimunekFuneral Home of Bel Air 610 W. MacPhail Rd. Bel Air, MD 21014 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ungesta disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No cate has been signed by the pege 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ≥ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy performed? 1 Yes 2 No certificate Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28c. Injury at Work? Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After t 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the P within 2. and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

30. Name and address of person who comcleted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

BI20PM

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Tyes 2X No

Inc.

Year

Approximate Interval Between Onset and Death

3012

MD

USA

Black, White, etc.

Specify: White

Month

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		Kedistrar	rtificate of Death	Reg. N	2012	1/32					
Physicia al Exami		1. Decedent's Name (First, Middle,Last) George Lawrence Stevenson, III		2. Date of Death Month Da May 18, 2012	y Year	Time of Death 1614 hrs					
		Facility Name (if not institution, give street and number) Johns Hopkins Hospital	4b. City, Town, or Location of I Baltimore		4c. County of Death						
Funeral Director		5. Social Security Number 203-50-7673 6. Sex 1 Months Days Hours Min. 12/05/1968 Foreign Court									
d how any 2c.		· · · · · · · · · · · · · · · · · · ·	Town or Location			0d. Inside City Limits Yes 2 No					
the Maryland or 28a-f show ified at once.	Director	10e. Street and Number 1439 Limit Avenue, Apt.E	10f. Zip Code 21218		Citizen of What Country	?					
or items 23.	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Americar White, etc.						
"natural", Examiner	<u>a</u>	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	Yes 2 No specify: 16a. Decedent's Usual Occupation (Give kin during most of working life. DO NOT us		specify: Blac b. Kind of Business/Indu						
Pages 1 and 2 should be filed within 72 hours after death with the Maryland lent of Health and Mental Hygiene. int. If item 27 is marked other than "natural", or items 23a or 28a-f shr other traumatic event, the Medical Examiner must be notified at once	Completed	17. Father's Name (First, Middle, Last)	Dispatch Supervison	T Name (First, Middle, Maide	ransportat	ion					
should be filed within and Mental Hygiene. To is marked other the matic event, the Med	Be	George Lawrence Stevenson, Jr. Mary Rebbecca Austin									
I and 2 sho Health and item 27 is r traumati			174 Kirkpatrick Dri	tta,Georgic c. Location - City or Tox	rgia 30064						
permit. Fages 1 and 2.8 Department of Health a Important: If item 27 injury or other traum		1 Burial 2 X Cremation 3 Removal from State Arc 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	crematory or other place) dent Cremation, Inc. 22. Name and Address of Facility N		anover,Mar						
로 최 道 급 ysician		Muchael F. Maryello 6009 Harford Road, Baltimore, Maryland 2 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart A									
ledical aminer		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of				Between Onset and Death					
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	f):								
and ransit	I Examiner										
ate be exe shysician a re burial -	Medical										
e attending phy for use as the b	Physician/N	23b. Was decedent pregnant in the past 12 months? 4 Pregnant at time of death 5 Other (Specify) 9 Unknown									
signed by the	2		esulting in the underlying cause given in Part I		o use contribute to the	_					
as been si	Completed			24a. Was an autopsy performed	prior to comp death?	sy findings available oletion of cause of					
se h	ΞI			1 105 2	No 1 Yes						
s certificate has irector, page 2 s	Be	25. Was case referred to medical examiner?	26.Place of Death (Ch		dance 6 Other:						
ending ruystetan: 1 ne la ath. wr. After this certificate ha he funeral director, page 2	To Be	examiner? 1 Yes 2 No 1 No Inpatient 2 27. Manner of Death Natural 5 Pending Natural 5 Pending	Other -	ursing Home 5 Resi							
prin of Attending Frysicians: The la wars after death. eral Director: After this certificate ha lilled in by the funeral director, page 2	ertification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined Natural 5 Vending Investigation 28e. Place of Injury - At ho	ER/Outpatient 3 DOA Other N N 28b. Time of Injury 28c. Injury at Work? 2330 hrs 1 Yes 2 N N N N N N N N N N N N N N N N N N	28d. Describe how i Subject Stabbec 28f. Location (Stree or Town, State)	njury occurred	Route Number, City					
lo und the rooping to a vicinity of the interior of the vicinity of the Kuneral Director: After this certificate he completely filled in by the funeral director, page 2	Certification: To Be	examiner? 1 Yes 2 No 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined (Space)	ER/Outpatient 3 DOA Other N 28b. Time of Injury 28c. Injury at Work? 2330 hrs 1 Yes 2 N Noome, farm, street, factory, office building, etc. ly Apt. ge, death occurred at the time, date and place and/or investigation, in my opinion, death occur	28d. Describe how in Subject stabbed or Town, State) 1439 Limit Avenue and due to the cause(s) red at the time, date and process of the state of the	njury occurred d and cut t and Number or Rural I e Apt. E, Baltimore, I and manner as stated. blace, and due to the ca	Route Number, City MD					
rhysic rathis	edical Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Multi-Famil 293. Certifier 1 Certifying Physician: To the best of my knowledge one) 2 Medical Examiner: On the basis of examination are	ER/Outpatient 3 DOA Other₄ N 28b. Time of injury 28c. Injury at Work? 2330 hrs 1 Yes 2 Noome, farm, street, factory, office building, etc. ly Apt. ge, death occurred at the time, date and place	28d. Describe how i Subject stabbed 28f. Location (Stree or Town, State) 1439 Limit Avenue and due to the cause(s) red at the time, date and p	njury occurred d and cut t and Number or Rural I e Apt. E, Baltimore, I and manner as stated.	Route Number, City MD uuse(s)					
vithin , To the comple	Medical Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Multi-Famil 29a. Certifier (Check only one) 2 Medical Examiner On the basis of examination ar and manner stated.	ER/Outpatient 3 DOA Other₄ N 28b. Time of Injury 28c. Injury at Work? 2330 hrs 1 Yes 2 ✓ No ome, farm, street, factory, office building, etc. ly Apt. ge, death occurred at the time, date and place nd/or investigation, in my opinion, death occur 29c. License number O.C.M.E.	28d. Describe how i Subject stabbed 28f. Location (Stree or Town, State) 1439 Limit Avenue and due to the cause(s) red at the time, date and p	njury occurred d and cut t and Number or Rural I e Apt. E, Baltimore, I and manner as stated. blace, and due to the ca d. Date signed (Month, ay 19, 2012	Route Number, City MD uuse(s)					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Jure 20 Y935 9:274 M ETHEL SOLLOD Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ROLAND PARK PLACE BALTIMORE Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days 263-07-3020 **Director** 1 □ M 2 🗓 F 96 09/08/1915 28a-f show 10b. County **Funeral Director** 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at 1 X Yes 2 □ No N/A MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 830 W. 40TH STREET, 21211 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner once. 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 X Widowed 4 Divorced WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) NURSE NURSING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 **EDWARD** LETT RHODA RUDOLPH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ESTHER LAYTON/DAUGHTER SLADE AVENUE, #510, PIKESVILLE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) HAR SINAI CONG. 06/05/2012 OWINGS MILLS, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ advanced chrome obstructure him disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Brenchisetasis equentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day Year 1 Yes 2 U Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death Pheck only one) Hospital Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide Director of by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d. Date signed (Month, Day, Year) > 17 Jahelle 013657 June 4, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THEREFOR, TOOW. TO KSTREET, BALTIMORE, OD ZIZII 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 0 1 2 1 7 9										
			Registrar 1. Decedent's Name (First, Middle, L.	T	110971101 2 0 1 12 1								
п	Physicia			351)		C A	CHS		2. Date of Dea Month MAY	31, Day 2012	ear	3. Time of Death 9:45 P M	
$\mathfrak{X}_{\mathcal{C}_q}$	Medic Examin		SHIRLEY F 4a. Facility Name (if not institution, gir	ve street and number)	SA		Location of Death		4c. County of		9:45 P ···		
*			FUTURE CARE C	HERRYWOOD			BALT		Œ				
	Funeral	П			ast birthday)	8. Date of Birt		. Birthpla Country	ce (State or Foreign				
	Director		220-20-5649 Usual Residence of Decedent	1 □ M 2 🗓 F	85	Yrs.			12/21	/1926		MD	
	land Fshov dat	ţō.	10a. State 10b. County		10c. City	y, Town or Loc	cation				100	d. Inside City Limits	
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	ems a	Funeral	3420 ASSOCIATE	12. Was Decedent E		S. 13. V		117 ispanic Origin? (Spe	ecify Yes or No-	USA 14. Race -	American	Indian	
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nd	e filed within 72 hours after dea ttal Hygiene. ed other than "natural", or itel event, the Medical Examiner	To Be	17. Father's Name (First, Middle, Last)						Maiden Surname)			
Maryland 21215-0036	2 should be fil th and Mental 27 is marked of traumatic ev	-	RAYMOND		KAT	1		MILDRED				RSCH	
Ma	25		19a. Informant's Name/Relationship STEVEN SACHS/Se							r, City or Town, State BURG, WV	e, Zip Coo 254		
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Baltimore,	permit. Page Department Important: I any injury o		21. Signature of Funeral Servic	рее		22	. Name and Addre	ss of Facility SC	L LEVIN	SON & BRO)S.,	INC.	
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Box 687	eath c	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)							23d. Date o Month	e of delivery nth Day Year		
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<u>q</u> .	requires that the des	by	Part II. Other significant conditions Dialetes		ut not resi	ulting in the ur	nderlying cause giv	ren in Part I.		bacco use contribut			
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<u>=</u>	iician: The certificate rector, paç		25. Was case referred to medical				26. Pl	ace of Death (Checi	1 Yes		Yes 2	□ No	
Vita	nysicia nis cer I direc	70 B	examiner? 1 Yes 2 X No	Hospital:	ent 2 🗌	ER/Outpatient	Oth	Ner:		ence 6 Other (S	Specify)		
o	ing Pl		27. Manner of Death 1★ Natural 5 □ Pending	28a. Date of injur (Month, Day)		28b. Time of injury	28c. Injury work	at at		ow injury occurred			
sior	Vttend death ctor: A ctor: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not	be 280 Blood of Injur	ını - At hoi	me farm etre		Yes 2 ☐ No	20f Location /C	trant and Number a	Down I De		
Division of Vital Records, P.O.	tal or A		4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						City or Town	treet and Number or n, State)	nuraino	oute Number,	
	To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours affect death. To the Funeral Director: Affer this certificate has been signed by the attending of completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Medical	(Check 2 L Medical Exar	ysician: To the best of r niner: On the basis of ex	kamination	and/or investi	gation, in my opinic	n, death occurred at	the time, date ar	nd place, and due to	the cause	(s) and manner stated	
	o the vithin 2 on the comple		only one) 3 Certifying Nu 29b. Signature and title of certifier	irse Practitioner: To the	best of m	ny knowledge,	death occurred at to	ne time, date and pla	ace, and due to th	ne cause(s) and mann 29d. Date signed (M	ner as stat	red.	
	->		Joan Clan	in CRUP				17786		June 1, 2			
			30. Name and address of person who	completed cause of de	eath (Item	23a) (Type, Pr	rint)	0		·			
	Clar		JOAN CLAVIN 31. Date filed (Month, Day, Year)	32 -			WN KOAD,	REISTERST	OWN, M.D.	21136			
	Stat Registra		JUN 0 6 2	2012	s Signati	1 6	uld						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 29 Month 2012 4:56 Рм David Tishler Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min Director 037-28-3604 1 🗓 M 2 🗆 F 67 6-30-1944 Rhode Island show at 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 X Yes 2 No Rockville MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1207 Fallsmead Way 20854 United States in U.S. 1967 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 and 2 should be filed within 72 hours after t.o 1 Yes 2 X No Specify: If Yes, Give "natural", 3 Widowed 4 Divorced 1969 White Year or Dates event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Lawyer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d Mental F marked o ပ Max Tishler Rose Weinblatt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health a 1207 Fallsmead Way, Rockville, Maryland 20852 Catherine Copp - Wife injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Garden of Remembrance 6-1-2012 4 Donation 5 Other (Specify) Clarksburg, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Danzansky-Goldberg 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1170 Rockville Pike, Rockville, Maryland 20852 Interval Between Onset and Death Hours Physician/ Acute Anterior Miocardial Infarction disease or condition Medical resulting in death) Examiner Coronary Artery Disease Unknown Sequentially list conditions, Examine it any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to for sers consequence of, Years Hypertension that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Years Hyperlipidemia Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? signed by the atte Day Month Year Pregnant at time of death 1 ☐ Yes ≥ L 9 ☐ Unknown 9 I Inknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 \square Yes 2 \square No 3 \square Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has performed? Yes 2 X 2 🗌 No 1 Yes filled in by the funeral director, I the Hospital or Attending Physician: hin 24 hours after death. Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita 1 ☐ Yes 2 🛣 No Other: 1 Npatient 2 ER/Outpatient 3 DOA ည 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work?
1 \quad Yes Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1X Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 10 29b. Signature and title of 20057032 6-6-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ١٦ Gregory Kumkumiah, MD - 6410 Rockledge Dr., Bethesda, Maryland 20817

Registrar
DHMH 17 Rev 06-2011

State

32. Registrar' Signat

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760 674

			State of Mar							_		Legibi	e.		
		1 - State Registrar		<i>y</i> 101.10		tificat					Reg. No.	201	2	17	925
Physicia Medic		Decedent's Name (First, Middle, Last) Rose Joan Tabb								2. Date of De Month	ath Day	2 0	12	3. Time o	
Examin	er	4a. Facility Name (if not institution, give st 3210 N. Leisure W		. #10	03			Location o				County of D			
Funeral Director			7. Age (I		t birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da	y, Year)		Country	ce (State o	or Foreign
land show dat	tor	Usual Residence of Decedent 10a. State 10b. County	1		Town or Loc								100	d. Inside C	ity Limits
ie Mary ir 28a-f notifie	Funeral Director	MD Montgome 10e. Street and Number	ry	Silv	ver Sp	10f. Zip	Code				10.000	zen of What	0		s 2 X No
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s after death ral", or item Examiner m	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	er in U.S.		Vas Decec Yes, spec				cify Yes or No- Rican, etc.)		14. Race - A Black, W Specify:	nite, et		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12	(Give k life. DC	Decedent's Usual Occupation Give kind of work done during most of working fe. DO NOT use retired) Cretary						16b. Kind of Business/Ind					
ld be filed w Mental Hygi arked othe atic event, i	To Be	17. Father's Name (First, Middle, Last) Howard Jacobs						(First, Middle, Lotenbe		aiden Surname) rg					
2 shou Ith and 27 is m		19a. Informant's Name/Relationship (Type Marvin Tabb – Spo								Route Number					906 MD
Page 1 and nent of Hea int: If item iry or othe		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)		cen	ce of Dispos netery, crem	sition (Nan natory or o	ne of ther place	9)	D	eate 2012	20c. Lo	ney, M	or Tow		
permit. Departn Importa any inju once.		21. Signature of Funeral Service Licensee	Edward Sa		22	. Name an	d Address	s of Facilit	y Edw	ard Sag	el F	uneral	L Di	rect	ion
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Medical Examiner		resulting in death)	Due to (or as a co		nce of):								<u> </u>		
ted T	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease of Injury b. Due to (or as a consequence of):													
be ex	g	that initiated events resulting in death) Last C. Due to (or as a consequence of): d.													
To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 X No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)								2	23d. Date of delivery Month Day Year			Year	
ires that the signed by ald be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributions contributions. 1 Yes 2 No 3													
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nding Phy: ath. r: After this ne funeral d	Certificate: To	27. Manner of Death 1X Natural 5 Pending 2 Accident Investigation		R/Outpatien Bb. Time of injury		Bc. Injury work?	at	2	ne 5X Resid			ecify)			
tal or Atters after de al Directo		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	e, farm, stre	street, factory, office 28f. Location					on (Street and Number or Rural Route Number, Town, State)				per,		
the Hospi hin 24 hou the Funer mpletely fil	Medical	29a. Certifier (Check only one) 2 Medical Examine 3 Certifying Nurse	r: On the basis of exan	nination a	nd/or investi	gation, in r death occ	ny opinior irred at th	n, death oc le time, dat	curred at	the time, date a ce, and due to t	nd place, he cause(s	and due to the and manne	e cause r as sta	ted.	anner stated
To with		29b. Signature and title of certifier Dr. Lilwing Yv. n	c- Man	cli	n c		License 0058					signed (Mo -2012	nth, Da	y, Year)	
20		30. Name and address of person who con Libuse Heinze-Mor					cord	St.	#500), Kens	ingt	on, Ma	ry1	and 2	20835
Stat Registra	•	31. Date filed (Month, Day, Year) JUN 0 6 2012	32. Registrar's	Signature	ares	•									

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 05 Physician/ 2012 10:55 A^M Raymond Harvey Twine Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 6218 Suitland Road Suitland If Under 1 Year If Under 24 Hrs. Social Security Numbe 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** 579-56-5813 68 Hours Min. 03/16/1944 Washington, DC **Director** 1 XM 2 □ F r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County should be filed within 72 hours after death with the Maryland Funeral Director 10c. City, Town or Location 1 Yes 2 No Prince George's Suitland MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA 20746 6218 Suitland Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces Black, White, etc. ģ 1 Never Married 2 X Married 2 XNo Yes Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working of Health and Mental Hygiene.
item 27 is marked other than other traumatic event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) <u>Freelance Photographer</u> Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ambrose Twine Mary Gray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 6218 Suitland Road Suitland, MD 20746 Gloria Twine/Wife Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State Metropolitan Crematory 5-29-2012 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall-March Funeral Home re of Funeral Service Licens 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has heen sinned by the Attending Continued. been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No funeral director, page 2 2 X No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 2 X No Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death nours after death.

neral Director: After the filled in by the funera 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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State Registrar

29b. Signature and title of ce

me and address of person who

of death (Item 23a) (Type, Print)

29c. License number

10430 Hospital DK.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 282012 CHARLES May LEE THOMAS, 6:04 a M Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince Georges Hospital Cheverly Prince Georges 7. Age (In vrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) **Director** 578-60-5935 1 🕱 M 2 🗆 F 63 Yrs. July 21, 1948 DC 28a-f show 10a. State 10b. County ural", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5212 Karl Place, NE 20019 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: "natural", 3 Widowed 4 Divorced Completed **Black** traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 2 yrs Director Private School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles L. Thomas, Sr. Hazel Brent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Sharon D. Thomas - wife 5212 Karl Pl.SE Washington, DC 20019 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glenwood Cemetery 6-2-2012 Washington, DC 21. Signature of Funeral Service Licenses MarshalTaMarchityFuneral Home of Maryland ecturine 4308 Suitland Rd. Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Acute Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Atherosclerotic Coronary Artery Disease Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last sician and burial-tran Due to (or as a consequence of): nding physician ause as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, End stage Renal Disease on Hemodialysis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has le 2 r this certificate has eral director, page 2 performe 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 PNo မ 1 Inpatient 2 FR/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at After (Month, Day, Year) Natural 5 Pending work? 1 Yes 2 No after death

Director: A

d in by the f Accident Investigation 6 Could not be Suicide 3 ☐ Suiciae 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours aft

To the Funeral Dii

completely filled in

State Registrar

Medical

29a. Certifier

(Check only one) 29b. Signature and ti

Richard Palmer, MD

0 6 2012

31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

1328 Southern Ave. SE Washington, DC 20032

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0055120

29d. Date signed (Month, Day, Year)

30 2012

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 06 2012 Arthur Burke Tymeson 4:20 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3537 Hickory Lane Baltimore Social Security Number If Under 24 Hrs 9. Birthplace (State or Foreign Could aryland If Under 1 Year **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Days (MO67307193) Hours 214-50-7947 60 1 1 M 2 □ F **Director** Usual Residence of Deced 28a-f shov Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or other traumatic event, the Medical Examiner must be notified at tYes 2 ☐ No MD **Baltimore** 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 3537 Hickory Lane 21211 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 Widowed 4 X Divorced Specify: Year or Dates. Air Force White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) t of Health and Mental Hygiene. If item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Construction Worker Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur A. Tymeson Lida Mae Burke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adele T. Connelly / Sister 11 Fernbrooke Drive, Safety Harbor, FL 34695 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or oth once. Date 20c. Location - City or Town, State Chesapeake Crematory 6/6/2012 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Due to (or as a consequence of) disease or condition resulting in death) year Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Error Ulicanying Cause (Disease or injury Due to (or as a consequence of) use as the burial-trail that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Be Completed by Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death signed by the at Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hyperlipidemia Records, 1 ☐ Yes 2 ☐ No 3 💢 Probably 4 ☐ Unknown Tobacco 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, pag Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Other: Certificate: To 1 ☐ Yes 2 💢 No 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 \sum Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D D \$ \$ 55698 June 05 2012 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Sungyon J 31. Date filed (Month, Day, Year) Baltimore. MD 21201 Jana 10 Norch Greene Street

DHMH 17 Rev 06-2011

State Registrar 32. Registrar's Signature

Registrar

DHMH 17 Rev 7/2009

State

8 CAMP MIGADIT RO!

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7.0

38 Registrar's Signature

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31. Date filed (Month, Day, Year)

JUN 0 6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2012 Turner 0545 RM 05 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/AGreneral Maryland Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🛣 M 2 🗆 F Hours 216-32-9518 76 0*5%*75*%*1936 Maryland **Director** Usual Residence of Decedent 28a-f show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mertal Hygiene.

Department of Health and Mertal Hygiene.

Department of Health is marked of other than "natural", or items 23a or 28a-f sho any or or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ ¥es 2 ☐ No MD N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1100 Pennsylvania Ave. #601 21201 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married à 1 Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 ☐ Widowed ♣️ Divorced Specify: Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12)
8th Grade College (1-4 or 5+) Laborer Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James William Turner Sr. Mabel Elizabeth Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leticia Smith(daughter) 1606 N. Gilmor St., Baltimore, MD 21217 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State King Mem. Park 06/04/12 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee 30sephddHsoffBrown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death
5 Julys Immediate Cause (Final Physician/ Preunonia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 phys the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ 9 ☐ Unknown Yes 2 No. P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, malnutni hon. end- stepe 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? +712 Z dinhehrs 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Division of Vital completed filled in by the funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 1743386 05.30.12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21217 121 Echew Mace 467 1714 32. Registras Signature e filed (Month, Day, Year)
JUN 0 6 2012

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Roger Wayne Wimer 4:00 June 1, Medical a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 214-48-6046 Director 1 🕅 M 2 □ F 64 July 23, 1947 West Virginia Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland Director 1X Yes 2 No Beltsville MD Prince George 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 ms 23a or must be r Funeral USA 4511 Brandon Lane 20705 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. ori 1 Yes 2 No
If Yes, Give
Year or Dates. þ 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than Kenilworth Mobile Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic according. Service Center Automobile Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Virgil Vernon Wimer Louella Kimble 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joy Wimer - Wife 4511 Brandon Lane, Beltsville, MD 20705 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Mt. Hebron Cemetery 1 X Buria 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify 6-5-2012 Maysville, WV 22 Name and Address of Facility Metropolitan Funeral Service 5517 Vine St., Alexandria, VA 22310 21. Signature of Funeral Service License cur 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final SPIRA FAILYRE Physician/ disease or condition resulting in death) Medical Examiner MONTHS Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HEMOPTYSIS 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown SIE NOSIS BRONCHIAL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed Yes 2 2 🗌 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 잍 N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Man of Death filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work s after death. 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie completely (Checi Partifying Nurse Practitioner To the best of my knowledge, destriconduct the time, date and place, and due to the histosoficiand manner as alstic unily o 29b. Signati of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

M. D.

32. Registrar's Signature

20874

20010 Century Blvd, Suite 200, Germantown, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Piotr Mikolas Wyrwinski,

JUN 0 6 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Maynth 27, Physician/ Helen Whitney Whitaker 2012 9:12 Рм Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 8. Date of Birth
(Month, Day, Year)
Sept. 23, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 229-44-4917 Director 1 □ M 2 🕅 F 73 193B Virginia 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 No Virginia Chesapeake 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1921 Robert Hall Blvd. Apt. 4302 23324 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Completed 3 Widowed 4 X Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. 12Administrative Assistant Bank of America Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles R. Whitney Catherine Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau John Charles Flowers (Son) 7809 Harder Ct., Clinton, MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Roland Cremation Service 6/8/2012 1 Burial 2 Cremation 3 Removal from State Norfolk, VA 5 Other (Specify) Conation 22 Name and Address of Faculty Metropolitan Funeral Service 5517 Vine St., Alexandria, VA 22310 Signature of Fineral Service Licen Le 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition icardic Medical resulting in death) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events ardiac Surgery burial-tran resulting in death) Last physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the SB IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death signed by the at d be detached for Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy perform death? 1 Yes 2 No 1 ☐ Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director; After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie

State

Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar Signat

Thomas Militano, M.D.

036207

11119 Rockville Pike #101 Rockville, MD 20678

May

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 31^{Day} Physician/ ${\rm May}^{\rm Month}$ 20T2 3:56 Рм Betty L. Wrightstone Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Dunda1k 3424 Yardley Drive Baltimore If Under 1 Year If Under 24 Hrs Months Days Hours Min. 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year, 182-22-0351 Director 1 M 2 TXF 88 June 12,1923 Pennsylvania Usual Residence of Decede 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 ☐ Yes 2XX No Dunda1k MD Baltimore 10e. Street and Numbe 'n 10f. Zip Code 10g. Citizen of What Country? be Funeral 23a 3424 Yardley Drive United States must h 21222 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. 0 by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 IX No 1 ☐ Yes ŽXX No Specify: Completed "natural" 3X Widowed 4 □ Divorced Year or Dates White traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 11 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Walter Keller Iona Weaver and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 21221 1726 Beechwood Ave. Essex, Maryland <u>Deborah K. Podles</u>(Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I-Important: If ite any injury or oti Page 1 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from Sta cemetery, crem Faith Cem. Baltimore, Maryland 5 Other (Specify) 6/5/2012 21. Signature Funeral Se Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland of 1. Enter the disease, or complications that caused the depth. Do not enter the mode of dying, such as cardiac of respiratory arrest nock, or heart failure. List only one cause of each line. Approximate Interval Between shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical nsequence of Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) be detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has performed 2 No Yes 1 Yes completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: ၉ 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred the Hospital or Attending thin 24 hours after death. 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 1 Yes 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Fractitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of person who c

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Division of Vital Records,

ause of death (Item 23a) (Type,

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980	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ked other than "natural", or items 2be notified at ic event, the Medical Examiner must be notified at	Completed by Funeral Director	11. Marital Status1 X Never Married.3 ☐ Widowed 4 ☐		12. Was Deced Armed Ford 1 Yes If Yes, Give Year or Dat	es? 2 X] No	l l	Vas Decedent of I FYes, specify Cub ☐ Yes 2X No	an, Mexicar	n, Puerto I	cify Yes or No- Rican, etc.)		ck, White	ican Indian, , etc. LACK	
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Baltimore,	T of F		20a. Method of Disposit 1 ☐ Burial 2 🌠 0 4 ☐ Donation 5	Cremation 3	Removal from S	tota C	emetery, cren VERDAL	sition (Name of natory or other pla E CREMAT	ORY	6/6/	2012	20c. Location	-		
Bal	permit. Page Department Important: any injury o		21. Signature of Funera	al Service Licens	ee Apro	alin	0-	Name and Addr		J.				L HOME, INC. AND 20785	
1	nynician/ Medical		23a. Part 1. End the c shock, or heart fa Immediate Cause (Fina disease or condition resulting in death)	ilure. List only o	ne cause on eac	used the death h line. The same of the sam	h. Do not ente	r the mode of dyi		cardiac o	r respiratory ar			Approximate Interval Between Onset and Death	
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. Box 68760	requires that the death certificate be been signed by the attending physici should be detached for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent pre in the past 12 mon 1 ☐ Yes 2 🔼 N 9 ☐ Unknown			irth 2 🗀 Feta ant at time of o	ıl death 3 🗌	Ectopic pregnar Other (specify)	су				ate of deli	very Day Year	
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on o	ading ath. rr. Afte he fun	icat	2 Accident	Pending Investigation	1	, Day, Year)	injury	M 1 C	κ́? ∐Yes 2. ⊑			,,			
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director,	al Certificate:	3 ☐ Sùicide 6 4 ☐ Homicide	Could not b determined	28e. Place d	f Injury - At ho g, etc. <i>(Specify</i>		eet, factory, office			28f. Location (City or Tov		per or Rura	al Route Number,	
	of the Hospital thin 24 hours at the Funeral Completely filled	Medical	(Check	Medical Exami	ner: On the basis	of examination	n and/or invest	occurred at the tin igation, in my opin death occurred at	ion, death o	ccurred at	the time, date a	and place, and d	ue to the c	ause(s) and manner stated	1.
	To the within To the comple	_	29b. Signature and title	of certifier	Um	WI	1.1	29c. Licens	642	08		29d. Date signe		Day, Year)	
	1		30. Name and address SAADIA HU			of death (Item	23a) (Type, P	rint)			IVERDI	ALE M	0 2	.0737	
П	Sta Registr		31. Date filed (Month, D	0 6 201	2 Per Re	gistrar's Signa		Nes!							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Marthy 30 20 12 8:20 AM WALDON SARAH R. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CLINTON 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days Hours 579-24-9825 87 Director 1 □ M 2 🔀 F OCT. 27 1924 WASHINGTON, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 🏋 Yes 2 □ No MD PRINCE GEORGE'S TEMPLE HILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20748 USA 6201 ALLEN COURT 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3X Widowed 4 □ Divorced Specify: BLACK Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ed other than " event, the Med Elementary/Secondary (0-12) 12TH College (1-4 or 5+) Mental Hygiene. MEDICAL RECORDS TECH GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 FRED HARRISON WALKER ANNIE MARIE WORMLEY and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6201 ALLEN COURT TEMPLE HILLS, MARYLAND 20748 ROZELIA M. HENDERSON/DGT. Health a Page 1 and 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important; If it any injury or o once. 1 X Burial 2 Cremation 3 Removal from State LINCOLN CEMETERY 6/6/2012 SUITLAND, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service License 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Ent of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or cardiac earliance on each line.

Immediate Couse (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if a y, leading to in real cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ☐ Live Birth 2 ☐ Fetal ueal ☐ Pregnant at time of death in the past 12 months?

1 Yes 2 No Month Dav Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Preumonitis 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed 2 🗌 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director After this certifica Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 X No Other: ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident
Suicide Investigation 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURRAIS ROAD MD CLENTON MD 20735 ADITYA 7503 KADIYALA

State

Registrar

31. Date filed (Month, Day, Year)

JUN 0 6 2012

1. Decedent's Name (First, Middle, Last)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

Physicia	ın/	1. Decedent's Name (_				2. Date of Dea	ath D	ay Year	3. Time of Death
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Examin	er			ive street and number)			4b. City, Town, or				4	c. County of Deat	
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eath v	Funeral Director	11. Marital Status		12. Was Decedent E	Ever in U.S.	13. V	/as Decedent of H	ispanic Or	rigin? (Spec	cify Yes or No-		14. Race - Ame	rican Indian,
fter d	by	1 Never Marrie	d 2 Married	Armed Forces? 1 ☐ Yes 2 🔀 If Yes, Give	No		Yes, specify Cuba ☐ Yes 2 ☐ No			Rican, etc.)		Black, White	
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Dispo 1 Durial 2	Cremation 3	☐ Removal from State			sition (Name of patory or other place Crema C	orv	6/5/	112		Location - City or	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2311 Barbara Yvonne Weatherholt UNE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** or Location of Death 4c. County of Death HOSP ITA MOR 7. Age (In vrs. last birthday) 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 216-60-9576 Hours Director 1 □ M 2 🏋 F 61 Sept.21, 1950 Maryland the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s dical Examiner must be notified Maryland Elkridge Howard 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 1 and 2 should be filed within 72 hours after death with of Health and Mental Hygiene.

The art of a marked other than "natural", or items 23a item 27 is marked other than "natural", or other properties of other traumatic event, the Medical Examiner must be other traumatic event, the Medical Examiner must be Funeral 8500 Hunt Club Road 21075 USA 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Education Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ William E. Allen Helen V. Vannatter 19a. Informant's Name/Relationship (Type, Print) . 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard A. Weatherholt-Husband 5800 Hunt Club Road, Elkridge, Maryland 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of I
Important; If its
any injury or or ŏ 1 X Burial 2 Cremation 3 Removal from State Elkridge, Maryland Meadowridge Mem. Park 06/06/12 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gary L. Kaufman F.H. @ MMP 21. Signature of Juneral Service Lice 7250 Washington Blvd., Elkridge, Maryland 21075 M01283 1. Enter the diseas complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. nly one cause on each line Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner PAILUR Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? perform 1 Yes 2 No 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 No Certificate: To 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6
Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) determined certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the (Check only one) 29b. Signature and afte of certific 29c. License number 29d. Date signed (Month, Day, Year) 06 03 30. Name and address of perso who completed ause of death (Item 23a) (Type, Print) OV 900 Montale 31. Date filed (Month, Day, Year) **JUN 0 6 2012** 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day} 2012 Month MAY WHITE RHEA 28 5:00A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1315 CHESACO AVE BALTIMORE APT 318 ROSEDALE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 217-12-3638 88_{Yrs} **Director** 1 □ M 2**X** F 1-26-1924 MARYLAND Usual Residence of Decedent or 28a-f shov 10a. State 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director BALTIMORE MD ROSEDALE 1 🗆 Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral **APT 318** 1315 CHESACO AVE 21237 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 9 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. "natural", Specify: WHITE 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 SALES DEPARTMENT STORE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ **ADAM** OHLE HELEN SAUTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21237 1315 CHESACO AVE APT 318 ROSEDALE, MD 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other transone GEORGE C. WHITE/HUSBAND Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State METRO CREMATORY 5-30-12 CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of FacilityCVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE 21237 ROSEDALE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 1 Yes 2 Month Year Pregnant at time of death 5 Other (specify) No be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one Hospital Other: No 1 Yes မ 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation after death Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 2300 ed *(Month, Day, Year)* **JUN 0 6 2012** 32. Registrar's Signature State

Registrar

Baltimore, Maryland 21215-0036 requires that the death certificate be executed burial-trar 68760 Box (been signed by the a should be detached Records, P.O. **Division of Vital**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem 26 per doc e928 6-6-12 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Margaret Williams Month Jun 3, 2012 Year 5:40 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4853 CastlebridgeRd **Ellicott City** Howard | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Min. | Months | Days | Year | Aug 5, 1931 Social Security Number Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 388-28-4509 WI Director 1 M 2 X F Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Warren NY **Brant Lake** 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 728 Hayesburg Rd. 12815 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc 1 Never Married 2 Married ğ 1 Yes 2 No White 1 ☐ Yes 2 No Specify: 3 ☐Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) **Credit Manager Financial** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harvey C. Johnson Arlene Maurer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4853 Castlebridge Rd. Ellicott City, MD 21042 Anna W. Roesch Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State etery, crematory or other place, Brant Lake Cemetery Jun 10, 2012 Brant Lake, NY 4 Donation 5 Other (Specify) 22. Name Stack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Signature of Fuheral Service Licensee 23a. Part 1 Enter the deate, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ CHRONIL OBSTRUCTIVE PULMONARY disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by IN SUFFICIENCY OF THE LEGS 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.
To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s autonsy performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No daughter's မ 1 Yes 4 Nursing Home Seedence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 \(\text{Yes} \) 2 \(\text{No} \) Natural 5 Pending injury Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 29b. Signature and ti 300. Date signed (Month, Day, Year)

JUN \$\frac{4}{5}\$, 2012 License number empleted cause of death (Item 23a) (Type, Print) 30. Name and address of perso DV ROUTE SUITE 10 MD 21738 GLENWOOD 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #6.per fh.g928 6-13-12 sm
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 936 am White da 2017 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SECOUVS Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 8 Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday, **Funeral** 4 X M 2 X F 51 Months 1/407/h003//98/960 Maryland 216-72-4589 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County ms 23a or 28a-f shor must be notified at 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 X Yes 2 ☐ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2003 W. Lexington Ave. 21223 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give within 72 hours after 1 ☐ Yes 2x No Specify: Specify: Black "natural" Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me 12th Grade (0-12) College (1-4 or 5+) Housekeeping Physics Laboratory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leroy White Alice Dukes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra White(sister) 2003 W. Lexington Ave., Baltimore, MD21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of E Important: If ite any injury or oth 1X Burial 2 Cremation 3 Removal from State Arbutus Cemetery 06/06/12 4 Donation 5 Other (Specify) Baltimore.MD 21. Signature of Funeral Service Licenses ਤੋਰੀਤਾਵਾਜ਼ੀ ਜਿਲ੍ਹਾ ਸਿੰਘ ਹਨ। Funeral Home 2140 N. Fulton Ave., Baltimore, I PA MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ OVACION disease or condition resulting in death) Medical Due to (or a consequence of) **Examiner** Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 1 Live Birth
4 Pregnant
9 Unknown in the past 12 months? Month Dav 5 Other (specify) Pregnant at time of death Yes 2 No 1 Yes 2 9 Unknown the ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy death? 1 ☐ Yes 2 ☐ No Yes To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 2 1100 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. iniury work? 1 ☐ Yes 2 ☐ No 1 Natural Accident 5 Pending Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State, 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c License numbe 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

KUD

6 2012

3altimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

32. Registra

2000 WEST Baltimore Street

Baltimore Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Wanda Sue Williams 30, 9:54 P May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore 1310 Kent Avenue Gwynn Oak 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours April 13, 1950 West Virginia Year) 234-84-8205 Director 1 🗆 M 2 🔀 F 62 or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Gwynn Oak Baltimore 1 Yes 2 No 0 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? ral", or items 23a or Examiner must be r Funeral USA 1310 Kent Avenue 21207 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌁 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. 3altimore, Maryland 21215-0036 nan "natural", o Medical Exam White 1 Yes 2 X No Specify. 3 Widowed 4 Divorced Specify. Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 n and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) the FBI 12 Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Relda Lee Carr traumatic Earl Franklin Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Thomas J. Hebron 6317 Mt. Ridge Road; Catonsville, MD 21228 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Highland Cemetery 6/4/2012 Cameron, West Virginia 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensee MO123 Edmondson Avenue; Catonsville MD 21228 1630 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ acute myccordial disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Pregnant at time of death the 1 ☐ Yes ∠∠ q Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autonsy perform 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2-100 ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify After this 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending I Director: A Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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State

Registrar

N. folling

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1120

Jucack IV MD

JUN 0 6 2012

31. Date filed (Month, Day, Year)

31, 2012

Cotonsville MD Z1228

Please Type or Print in Black indelible ink./Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 5:49 P ^M 2012 Medical CONSTANCE YOUNG JUNE 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S 3109 AMADOR DRIVE LANDOVER Birthplace (State or Foreign Country)
 NEW JERSEY If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Director 1 🗆 M 2 😾 F MAY 2 1912 100 28a-f shov iral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD PRINCE GEORGE'S LANDOVER 1X Yes 2 □ No 10g. Citizen of What Country? 10e, Street and Numbe 10f. Zip Code Funeral 20785 3109 AMADOR DRIVE USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: BLACK 3 X Widowed 4 Divorced "natural", Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) ADMINISTRATIVE ASSISTANT GOVERNMENT 12th permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If Item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of မ RICHARD COY MARTHA BRENT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3109 AMADOR DRIVE LANDOVER, MARYLAND 20785 MELLISA PUMPHERY/DGT 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 6/5/2012 4 Donation 5 Other (Specify) RIVERDALE, MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. TIC Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner draule Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ohysician and the burial-transit that the death certificate be executed Division of Vital Records, P.O. Box 68760 CC Due to (or as a consequence of): resulting in death) Last Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 4 ☐ Pregnant at time of death g ☐ Unknown 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗆 No Yes 2X No or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 $\overline{\mathbf{X}}$ Residence 6 \square Other (Specify) 2 No ျ ER/Outpatient 3 DOA 1 Inpatient 2 I filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28c. Injury at work? 28d. Describe how injury occurred after death. Director: After 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral I.

completely filled

State Registrar

Medical

29a. Certifier (Check

31. Date filed (Month, Day, Year)

Signature and title of certifie

me and address of person the completed cause of death (Item 23a) (Type, Print)
FARHAD JAMALI MD 12150 ANNAPOLIS ROAD # 308 GLENN DALE, MARYLAND 20769

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

JUNE 5, 2012

Certifying Nurse Practitioner: To the Best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License numbe

D 58213

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 25 Day May Physician/ 20Î2 1805 Рм Alfred Louis Allen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ceci1 E1kton Union Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🕅 M 2 🗆 F Months Days Hours DEC 4, 1949 222-34-0644 62 Kentucky **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 ☐ Yes 2 🗓 No Marvland Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 183 Knights Corner Road 21921 United States 12. Was Decedent Ever in U.S. Armed Forces? 1968-1 1971 Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Stee1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Dollie Mullins George Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 183 Knights Corner Road, Elkton, MD Linda Allen/Wife 20b. Place of Disposition (Name of Chemitary, Hamilary or other place) Methodist Cemetery 20a. Method of Disposition 20c. Location - City or Town, State May 30. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cherry Hill, MD 22. Name and Address of Facility Ricks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Annroximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner 6 hrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a cons. quence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death for use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 9 Unknown cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed' death? certificate ! 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical the funeral director. Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မ 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending after death. Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined 24 hours a Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certifier 29d. Date signed (Month. Day. leted cause of death (Item 23a) (Type, Print) 30. Name and address of person who cor OVO DYC ynn

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Anthony Cornelius Badger 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Nicomico MADICAL 3BU/30U/4 KLGIONAL If Under 1 Year If Under 2 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days (Month, Day, Year) Hours Min Director 220-52-0248 1**∑** M 2 □ F 2-1951 MD 61 show 10d, Inside City Limits 10b. County 10c. City, Town or Location death with the Maryland autment of Health and Mental Hygiene. oortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 💢 No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes, 2 M No If Yes, Give Year or Dates. USZ 923 East Church 21804 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important if frem 27 is marked others any injury or others? Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Spec Back 3 Widowed 4 XDivorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) Co life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Knoll Construction 10 Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harrison Robinson Gladys Mae Badger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Decatur Avenue, Salisbury, Toni Badger/Daughter MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other pace) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 5-18-2012 Dover, DE 4 Donation 5 Other (Specify) Cremation, 22 Name and Address of Facility 917 W. Isabella St. Bennie Smith Signature | Funeral Service Licensee Salisbury, MD 21801 Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Pancre Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant □ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Other (specify) 1 Yes 2 L 9 Unknown page 2 should be detached Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 Yes 2 No After this certificate filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 🔀 No ၉ 1 Tes 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 X Natural 5 - Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c, License number 1005619who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person E-Carroll St. Saluby 00 100 31. Date filed (Month, Day, registrar's Signatur State MAY Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

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		For State Registrar		State of	Marylan	-	artment of F <i>rtificate of I</i>			/lental Hy	/gier Reg. N	26	112	17	945
		1. Decedent's Nam	e (First, Middle, La	st)						2. Date of De	eath	- Banga		3. Time of	Death
cia: tica		Hollis	Levin Ba	ilev. Jr	c.					Month May 16		012	Year	11:5	55 AM
ine		4a. Facility Name (4b. City, Town, or	Location	of Death	1100) 10		c. County	of Death		
		1054 E.	Schumaker	Manor			Salis	bury				Wic	omic	0	
al		5. Social Security N			. Age (In yrs.		If Under 1 Year Months Days	If Unde Hours	r 24 Hrs. Min.	8. Date of Bi (Month, D	rth av. Yea	r)	COL	place (State or	
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	ğ	3 Widowed		If Yes, Give Year or Dat	No 194 es: 194	6	1 ☐ Yes 2 🖾 No	Specify	<i>/</i> :			Specify	/:	white	
	eg		15. Decedent's Ed	ducation	17	16a. Dece	dent's Usual Occup	ation			16b.	Kind of Bu	usiness/li	ndustry	
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	Be	17. Father's Name	(First, Middle, Last)				18. Moth	ner's Name	e (First, Middle	, Maide	en Surnan	ne)		
	0	Hollis	Levin Ba	ailey, Si	r.			Mary	y Lou	ise Par	rker	•			
ľ	i	19a. Informant's N	ame/Relationship ((Type. Print)		19b. Mailii	ng Address (Street	and Numl	ber or Rur	al Route Numl	per, City	or Town,	State, Z	p Code)	
		Jean 7	Twilley B	ailey (Wife)	1054	E. Schum	aker	Mano	or Sa	lis	bury,	MD	21804	
		20a. Method of Dis	•		20b. P	lace of Dispo	osition (Name of matory or other plac	re)	[Date	20c.	Location -	City or T	own, State	
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	nys	9 ☐ Unknown		9 🗆 Unknov	wn										
6	<u>ک</u> ح	Part II. Other signi	ficant conditions	contributing to dea	ith but not resi	alting in the u	nderlying cause giv	en in Part	1.	23e. Did	tobacc	o use cont	ribute to	the cause of de	eath?
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		25. Was case refer	rred to medical					26 Place	an of Doot	1 ☐ Yes h (Check only		10	1 ∐ Yes	2 No	
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	123	3 Suicide	6 Could not b	e 28e, Place o	of Injury - At ho	me, farm, str	reet, factory, office			28f. Location	(Street	and Numb	er or Ru	ral Route Numi	ber,
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	g	(Check only one)	2 Medical Exa	miner: On the bas and manne	sis of examina er stated.	tion and/or ir	nvestigation, in my o	pinion, de	eath occur	rred at the time	, date a	ınd place,	and due	to the cause(s)	1
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tate		31. Date filed (Mor	nth, Day, Year)	32. R e	gistrar's Signa	ture			1,1-40	1 11		11		50, 101	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Preston Carl Bowling Month 0715 M May 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Salisbury Rehabilitation Nursing Wicomico sbun If Under 24 Hrs 8 Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 X M 2 □ F Months Days 214-32-9912 Director 03/16/1935 Maryland Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Marvland Wicomico Pittsville 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21850 34740 Poplar Neck Road USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. δ 1 X Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir Baltimore, Maryland 21215-0030 1 ☐ Yes 2 ■No Specify: Completed 3 - Widowed 4 - Divorced White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Building mechanic Verizon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Preston Carl Bowling Sr. Bessie Harriet Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 34740 Poplar Neck Rd., Pittsville, MD 21850 Marian T. Bowling / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🗎 Removal from State Pittsville Cemetery 5/18/2012 ☐ Donation 5 ☐ Other (Specify) Pittsville, MD ignatule of Funer I Service Licensee Holloway Funeral Home Professional Association Mongoon 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Immediate Cause (Final ∳nysician/ andio var culo horosolvetic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or). attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 No page 2 🗌 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 NO Hospital Other: 1 Yes 잍 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work?
1 Yes 2 No 1 Natural 5 Pending in 24 hours atter ucu...the Funeral Director. Aff Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and ti completed cause of death (Item 23a) (Type, Print) Name and address of person who choler Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First Middle Last 2. Date of Death Physician/ Month 2:54 PM Bell Clara Mae 20/2 6 Medical 4a. Facility Name (if not institution. give street and number Town, or Location of Death 4c. County of Death Examiner Wicomi 0 If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 218-14-4065 Director 1 M 2 X F 90 05/02/1922 Maryland Usual Residence of Dec 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director must be notified 28a-f 1 Yes 2 X No Pittsville Maryland Wicomico 10e. Street and Number 10g. Citizen of What Country? 9 Funeral 23a 34374 Main street 21850 USA or items Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces Black, White, etc 1 Yes 2 No ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 XNo Specify Specify: than "natural", White 3 X Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Certified Nursing Assistant Health Care is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ermal Elliott Rome Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5625 Morris Rd., Pittsville, MD 21850 27 Tom Bell/Son or other timore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Parker Family 1 🗷 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) 5/19/2012 Pittsville, MD Cemetery 21. Signature Funeral Service Licenses HolToway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ARIDIOMY Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury attending physician and I for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death detached the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? Yes 2 No certificate 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \(\text{Yes} Other: ပ HOSPI43 1 Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence of Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Director: After Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 10005 TC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WAR

Registrar

State

31. Date filed (Month, Day, Year)

18

12-03722 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Isabel Gladys Blanco State of Maryland / Department of Health and Mental Hygiene 2012 17948 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death ₱hysician/ Month Day May 15, 2012 **Medical Examiner** 1011 hrs Isabel Gladys Blanco 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional Medical Center Salisbury Wicomico 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Hours Day: Director 589-13-0908 1 M 2 X F 58 12/25/1953 Uruguay Usual Residence of Decedent 10d. Inside City Limits any 10c. City, Town or Location 28a-f show 1 Yes 2 X No permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. /irginia Accomack Atlantic 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 33035 Collins Lane 23303 USA Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican. etc.) White, etc. 1 Never Married 2 Married 2 X No Yes 1 X Yes 2 No specify: Uruguay Specify: Uruguay 3 X Widowed 4 Divorced If Yes, Give Year Š 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Business Owner Construction 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) B Ramona Cabral Gerardo Blanco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Bounds/Daughter 27638 Walnut Tree Rd., Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date Itimore, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State 5/22/2012 Salisbury Crematory Salisbury, MD 4 Donation 5 Other Specify 21. Signature of Funeral Service Licens ²²Name and Address of Facility HOILOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 **Physician** Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and failure. List only one cause on each line /Medical a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Sa e attending physician a for use as the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Fetal death Live birth 3 Ectopic pregnancy Month past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown the has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 줕 1 Yes 2 No 3 Probably 4 Unknown Completed this certificate has been il director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) æ examiner? Hospital: 1 Inpatient Other₄ ER/Outpatient 3 V DOA Nursing Home 5 2 Residence 6 Other 1 Yes 2 No 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 8c. Injury at Work? 28d. Describe how injury occurred 1 Natural May 15, 2012 Driver auto auto collision 0932 hrs Pending 1 Yes 2 ✔ No the 2 🗸 Accident 28f. Location (Street and Number or Rural Route Number, City

Certification within 24 hours after death To the Funeral Director: filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) Chincoteague Rd. near Rt. 13, New Church, VA determined (Specify) Local Street Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sa 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 16, 2012 Alldo arde ISTC

30. Name and address of person who completed cause of death (Item 23a)

Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day Year)

State Registrar

ORIGINAL desse-

egistrar's Signature

Death

Year

2 No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Rov Buckheit Physician/ 05^{Month} 20g) 2012 9:30 pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death **Examiner** 4c. County of Death Frostburg Village Nursing Center Frostburg Allegany Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign Funeral 6. Sex 1 M 2 □ F Months Days Hours 1171671935 Director Brooklyn, NY 058-28-8647 76 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 214 Delano Street 21532 U.S.A. Id be filed within 72 hours after death v Mental Hygiene. 12. Was Decedent Ever in U.S.
Atmed Forces?
1 2 Yes 2 No 1958.
If Yes, Give 106.2 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or) ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: White "natural", Completed 3 Widowed 4 ☐ Divorced 1963 Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) the 4 Communications Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Charles Buckheit Margaret Leonard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn Ketterman 214 Delano Street, Frostburg, MD 21532 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State George Washington MEM. 06/02/2012 Paramus. NJ 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Sowers Funeral Home. Ma057/7 60 W. Main Street Frostburg, MD 21532 Nes 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death ZHEIMER Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examin Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year Pregnant at time of death 2 No g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PARICINSDNISM 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🔁 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Winsing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Hospital or Attending P 124 hours after death.
 Funeral Director: After the Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D 26907 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd SidhuMD 925 Bishool) Cumberland MD 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Box 68760

Records, P.O.

Division of Vital

Amend #20b per AA Co. Health D		10		Type or Pri								_	ble.		
	_	Fo, AMEND#2	29D per FH,F 7/2012 AACC	HYState of M HEALTH DEPT	aryland '. OMH	d / Depa <i>Cer</i>	artment of tificate of		and Me		giene Reg. N	20	12	-	1950
Physici			e (First, Middle, Las	st)		-	/ 1 /			2. Date of De Month	-	av.	Year	3. Time	of Death
Med Exami	ical	4a. Facility Name (ii	f not institution, give	street and number))/V/V	OLL	4b. City, Town,	or Location	of Death	5	7	3 20 c. County of	of Death	9:9	5 PM
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003(urs afte tural", al Exar	ted b	3 X] Widowed		1 Å Yes 2 ☐ If Yes, Give Year or Dates.	Arm		☐ Yes 2 🗓 N		<i>r</i> ;			Specify:		ite	
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e, Maryland 21215-0036 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygene. tem 27 is marked other than "natural", or items 23a or 28a-f sho ther traumatic event, the Medical Examiner must be notified at			ame/Relationship (7	ype, Print) onnolly/da	ughte		g Address <i>(Stree</i> 407 Star							ode)	
Baltimore, Poermit. Page 1 and 2 Department of Health Important: If item 2 any injury or other 1 any injury or other 1 mone.		20a. Method of Dis 1 X Burial 2		Removal from State	20b. Pla MDce	ace of Dispo	sition (Name of	æry¦	UNK Da			_ocation ~ (
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Peri Depri any		100	nound	MO	DK	0) 65	512 NW C	rain l	Hwy, l	Bowie,	Mar		1 207	'15	
- Table 1		23a. Part 1. Enter shock, or hea Immediate Cause	rt failure. List only o	plications that caused one cause on each line	e.							1	7.	Approxim Interval B Opset ap	etween
Ply i i an Medica Examine		disease or condition resulting in death)		a. Due to (or as	E RE	ence of):	LVA	Scal	CAR	HC	C/!	DEN			75
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Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate be et thours after death. Funeral Director: After this certificate has been signed by the attending physicial attending to the funeral director, page 2 should be detached for use as the bur	Physician/Medica	23b. Was decedent in the past 12 1 Yes 2 9 Unknowr	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a g Unknown	2 🗀 Fetal	death 3 [Ectopic pregnal Other (specify)	псу			8	23d. Date Mon	e of delive nth	ry Day	Year
P.O. s that the gned by be deta	þ	Part II. Other signi		contributing to death b		Iting in the u	nderlying cause o	iven in Part	t I.			use contril			-
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Division To the Hospital or Attention within 24 hours after deat To the Funeral Director:	Medical (29a. Certifier (Check 2	Medical Exam	sician: To the best of siner: On the basis of e	xamination	and/or invest	igation, in my opir	nion, death o	occurred at the	he time, date a	and plac	e, and due	to the cau	se(s) and r	manner stated.
To the within 2 To the comple	ğ	only one) 3 29b. Signature and	4 /	se Practitioner To the	e best of m	y knowledge,	29c. Licen	_	ate and place	e, and due to		e(s) and ma			2012
		30 Name and addr	ess of person who	completed taluse of d	leath (Item	23a) (Type. P	rint) U	115	101	ONCA	<u>//</u>	Jech	<u> </u>	N	1901
· ·	0	Mich	AEL ~	(at Eo	ATZ	W	4	An	inpe	dlis,	M	0	21	401	
Sta Regist	ate rar	31. Date filed (Mon	AY 1820	12 Sheve	ar's Signatu		Wed .								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death , 2012 Physician/ Mary Patricia Cole May 13, 9:00 \mathbf{a}^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ATLANTIC GENERAL HOSPITAL BERLIN WORCESTER If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Hours 218-28-0032 Director 1 🗌 M 2 🕱 F 80 03/13/1932 Maryland Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland Worcester Berlin 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number o or than "natural", or items 23a of the Medical Examiner must be Funeral 227 Ocean Parkway 21811 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. ρ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene.
Important if item 27 is marked other than "n.
any injury or other traumatic exercises." Elementary/Secondary (0-12) College (1-4 or 5+) 12 Office Worker Clerical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Theresa Lachman Raymond C. Cole Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Guagliano/Niece 702 S. Surf Rd., Ocean City, MD 21842 20a. Method of Disposition 20h. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 \square Burial 2 X Cremation 3 \square Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/16/2012 Salisbury, MD Salisbury Crematory 21. Signature of Funeral Service Lice 22. Name and Address of Facility Holloway Funeral Home Professional Association Voil 1 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one duese on each line. Approximate Interval Between Onset and Death Abdominal Immediate Cause (Final Physician/ Ruptured disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Hypertension Socie, tially liet conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Day Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting In the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed 1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Vita B B 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 욘 1 🗌 Yes 2. No 1 Inpatient 2 FR/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 5-14-12 H006646Z 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10514 Racetrack Rd Berlin, mp 21811 Jeffrey Scheirer Po

State Registrar

13/3019

13/1932

MARJORIE CAMPBELL

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Marjorie Ann Campbell 2012 May 2030 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death E1kton Ceci1 30 Avalon Avenue Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours Min. 1 □ M 2 🏋 F Maryland Director 219-30-1766 Usual Residence of Decedent 10a. State 10b. County "natural", or items 23a or 28a-f sho dical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No E1kton Maryland Ceci1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 30 Avalon Avenue 21921 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married b Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Operator Telephone Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Clarence Biddle Kathryn Taylor Page 1 and 2 should I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Charles Campbell/Husband 30 Avalon Avenue, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🕅 Burial 2 🗌 Cremation 3 🗌 Removal from State June 4, 4 Donation 5 Other (Specify) Elkton Cemetery 2012 Elkton. MD of Funeral Service Licensee 22. Name and Address of Facility Hicks Rome for Funerals, 21. Signatu 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to minediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pagn 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in rity opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD DOG2190 5/30/12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 HAHNAWAZ KHAN MD

2533 AUGUSTINE HERMAN HWY, SVITEA, CHESAPEAKE CITY, MD21915 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jean Fulton Dixson 2012 10:00 Medical May 16 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ginger Cove Health Center Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 215-44-4118 (Month, Day, Year, Director 95 1 M 2 TX F 1916 Yrs July 4, Nebraska perint. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Direct Anne Arundel Davidsonville 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2542 Vale Court Funeral 21035 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2XXXNo Specify: Yes Give White Specify: 3XX Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work dane during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last)
Harry Fulton 18. Mother's Name (First, Middle, Maiden Surname) Helen Johns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Herbert Lee Dixson, Jr./son 2542 Vale Court Davidsonville, Maryland 21035 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 XX remation 3 Removal from State Baltimore Crematory 5/18/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Juneral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ onses Tive disease or condition resulting in death) 4 CAVS Medical Due to (or was a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attendion above. for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month Dav Year Pregnant at time of death been signed by the a should be detached Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 🗌 No Yes 2 No 1 🗌 Yes ours after death.

eral Director: After this certifical filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cer 29c. License number 165 person who completed cause of death (Item 23a) (Type, Print) 5 0 State Registrar's Signature Registrar

Box 68760

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Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 30 A-M DENNIS SHARON R. 2012 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Hospice at the salis bury Coastal WICOMICO 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral 216-40-0191 Director 1 □ M 2 🗓 F 69 MARYLAND OCT. 21, 1942 Usual Residence of Decedent 28a-f shov 10a. State 10b County 10c. City, Town or Location 10d, Inside City Limits notified at Director 1 Tes 2 X No SUSSEX SELBYVILLE DELAWARE 10e. Street and Number ь 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a 19975 USA 36395 HUDSON ROAD 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. 9 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: "natural", 3 Widowed 4 Divorced WHITE Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) RESTAURANT BARTENDER 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ BUTLER **GEORGE BRADY** BEULAH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT M. DENNIS/HUSBAND 36395 HUDSON ROAD, SELBYVILLE, DE. 19975 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 5/17/12 ROXANA, DELAWARE ROXANA CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licenses 21. Signal e 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part 1. Enter the disease, or complications that caused ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death DISPLASE CHRONIC Physician IDNRY disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events Due to for be a consequence of requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical the as attending p IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy performed Yes 2 death? certificate ! 1 Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: HOSPI CZ ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence Cother (Specify) eral Director: After this ifilled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Matural Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Dennis

Division of Vital Records, P.O. Box 68760 the Hospital or Attending within 24 hours a

To the Funeral D

completely filled

Registrar

Medical

4 Homicide

only one) 29b. Signature an

29a. Certifier (Check

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PU Bre 6 Huyam 31. Date filed (Month, Day,

determined

Year)

Registrar's Signatu

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0058410

certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

21802

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death Req. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Mary Jane Ekstein 2012 10:07 A M May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 1307 McKinley Street Annapolis Social Security Number 6. Sex 7 Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Month, Day, Y Dec. 28, 306-38-5080 ่ 1938 73 Indiana Director 1 - M 2XXF Yrs ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10c. City, Town or Location Director Maryland Anne Arundel Annapolis 1XXYes 2 ☐ No 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? 21403 Funeral 1307 McKinley Street U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian than "natural", or iter he Medical Examiner Black, White, etc. ģ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 within 72 hours after White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) the Executive Secretary Northrop Grumman 12 of Health and Mental Hygie item 27 is marked other other traumatic event, the Be permit. Page 1 and 2 should be filee.
Department of Health and Mental Hw. Important: If item 27 is markany injury or other. 18. Mother's Name (First, Middle, Maiden Surname)
Loretta Reising 17. Father's Name (First, Middle, Last) Herman Ekstein 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 1026 Blackwell Road Annapolis, Maryland 21403 Kevin Washington/POA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XXBurial 2 Cremation 3 Removal from State Hillcrest Mem. Gardens 5/19/2012 Annapolis, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home odd 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCEL Physician/ JAG disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) that the death certificate be executed burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 the as IF FEMALE: IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 mo 1 Yes 2 N 9 Unknown 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 Yes 2 No Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) of Vital Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Division 24 hours after death. Funeral Director: A 2 Accident
3 Suicide Investigation Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Gettifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 16/2012 MI

Year

State Registrar 31. Date filed (Month

medical Parking Sute 20

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAY 18 2012

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

Amend Iine 23a (line c), per MD, 44, 10-22-2013, GDY

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1255 p M 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 213-30-1003
Usual Residence of Decedent Director 1 □ M 2 🗓 F 81 9/20/1930 Maryland "natural", or items 23a or 28a-f show dical Examiner must be notified at 10b County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 9209 River Crescent Drive 21401 USA 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene. item 27 is marked other than "nah.mall" as item 27 is marked other than "nah.mall" as item Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 XNo Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Yes, Give 3 Midowed 4 □ Divorced Completed Specify Year or Dates White f Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker years Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Federick Nelson Smith Anne Raedy Callahan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 Emerson Road, Severna Park, Maryland 21146 Alexandra K. Reynolds/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Ignatius Ch. Cem. 5/19/12 Forest Hill, MD 21. Signatur f Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of Ischemic Cardiomypathy and resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy
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1 Yes 2 No for Pregnant at time of death Other (specify) Month Day Year g 🗌 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? To the Hospital or Attending Physician; The law within 24 hours after death.

To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 si 24a. Was an autopsy performed 2 🗌 No 1 🗌 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 72606 05-17-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 . Date filed (Month, Day, Year) State Registrar's Signature MAY 182012 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Phyllis Lucille Foxwell Medical Mav 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 13870 Backbone Road Eden Worcester Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Hours Days (Month, Day, Year) Director 70 216-38-9057 Yrs. 09/05/1941 Maryland Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🏻 No Maryland Worcester Eden 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13870 Backbone Road 21822 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Telephone Operator Communications Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Norman Nuse Susie Mary Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie Culp/Daughter 31960 Pine Acres Dr., Princess Anne, MD 21853 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 200. Place of Disposition (Name of cemetery, crematory or other place) Anatomy Giits Registry 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 5/15/2012 Hanover, MD 21. Signature of Funeral Service Name and Address of Facility al Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Part 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Physician/ Onset and Death ONSTON disease or condition -m2Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence ory as the burial-transit Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) Year detached 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed 2 No 3 □ Probably 4 □ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy After this certificate funeral director, pag Yes 2 No 25. Was case referred to medical l a 26. Place of Death (Check only one) 1 Yes 2 X-No |2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending death. Accident Investigation s after death Suicide Homicide 6 Could not be à Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State, To the Hospital o within 24 hours af To the Funeral Di completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in multiplication in multiplication in multiplication. Medical 29a Certifie 2 deficial Examiner: On the basis of examination and/or investigation, in my opinion, death pace, and due to the cause(s) and manner stated 3 defining Nurse Practitioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 20507 5 15 12220 30. Name and address of pers eted cause of death (Item 23a) (Type, Print) CARROLL St, SALISBURY 20 Ŏ 31. Date filed (Month, egistrar's Signatur State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 27, 2012 Year 10:15 PM Cecelia **Fauss** Mary Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Allegany Cumberland Golden Living Center Birthplace (State or Foreign Country)
 MD Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 □**y** Feb 1 1. Director 219**-**46-0715 79 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director Allegany Cumberland MD 1 Xes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21502 USA 11915 Mulberry Avenue hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 Never Married 2 Married δ Yes 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: If Yes Give "natural", white Completed 3 Divorced 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ൧ Severina Delluomo permit. Page 1 and 2 should be i Department of Health and Ments Important: If item 27 is markec Phillip Giovinali 19a. Informant's Name/Relationship (Type, Pn'nt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 710 Edgevale Avenue Cumberland MD 21502 Teresa Howsare daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park 5/30/201 MD Cumberland Donation 5 Oper (Specify) of Funeral Ser 22. Name and Scarpelli Full Yeral Home, PA any 108 Virginia Avenue: Cumberland, MD 21502 Enter the disease. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a, Part 1 shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ End one vem disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and-trar Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N cate has bage 2 s certificate 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 1 Natural 28d. Describe how injury occurred hin 24 hours after death. the Funeral Director: After in ppleted filled in by the funera iniury 5 Pending 2 No Investigation 'Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year, mock D005532 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month A Lawrence Delmar Golden 2012 1309 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Medical 3ALI 3641 NICOMICA **Funeral** Age (In vrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Davs 2-17-1934 Director 186-28-4960 78 1 🛛 M 2 🗆 F Pennsylvania Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. Count 10c. City. Town or Location Director 10d. Inside City Limits DE Sussex Bridgeville 1 🗆 Yes 2 🖁 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 67 Canvas Back Circle 19933 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? or i þ 1 X Never Married 2 Married and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes Give 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Vice President Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ပ Ralph W. Golden Vivian Hess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra (Partner) Richard Whaley 67 Canvas Back Circle Bridgeville, De. 19933 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Laurel Hill Cemetery 5-15-2012 Laurel, Delaware 21. Signature of Funeral Service Licensee 700 West Street 22. Name and Address of Facility Hannigan, Short, Disharoon F.H. Short Laurel, De. 19956 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease Or Injury that initiated events burial-trai Due to (or as a consequence of): resulting in death) Last physician by Physician/Medical Box 68760 use as the attending IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy for Pregnant at time of death Month Day Vear Other (specify) should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed 1 Tes 2 No 3 Probably 4 No Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed Yes 2 X N 2 No I or Attending Physician: after death.
Director: After this certifications the funeral director. Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 IX No Other: 1 🗓 Inpatient 2 🗌 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral D Medical 29a. Certifier K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and ti 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

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31. Date filed (Month, Day,

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Certificate of Death

3. Time of Death

2. Date of Death

1 - For State Registrar

Decedent's Name (First, Middle, Last)

The law requires that the death certificate be executed After thi

Division of Vital Records, P.O. Box 68760.

Day 2012 12, May Eunice Ophelia Handy 5:40P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Daisey's Assisted Living Pocomoke City Worcester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) 1 ☐ M 2 🗗 F Months Days Hours 91 215-20-4267 Director Aug. 01/ Maryland Usual Residence of Deceden 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ¥Yes 2 No Director MD Worcester Pocomoke City 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21851 USA 302 Market Street Completed by Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) llth Domestic Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Derickson Rachael Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10401 Trappe Road - Berlin, Maryland 21811 Sarah D. Mitchell/ Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State New Bethel UMC Cemetery May 17, 2012 4 ☐ Donation 5 ☐ Other (Specify) Berlin, Maryland 22. Name and Address of Facility Salisbury, Maryland 21. Signature of Funeral Service Licensee Jolley Memorial Chapel - 1213 Jersey Road 21801 23a. Part1. Enter the disease, or complications that crused the death shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and for use as the burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t director, page 2 s autopsy performed? 1 🗌 Yes 2 No 28 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဥ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a Fo the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and tyle of certifier 29c. License number GRAD R. BARAL; MY 54422 05-18-2012 1604-K 2185 focomo. 31. Date filed (Month, Day, Year) egistrar's Signature 32. State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 17961 for State Registrar Certificate of Death

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyliene.

Physi Me

Exan

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be exe within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician: Division of Vital Records, P.O. Box 68760

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neral ector		5. Social Security No. 577–38–75 Usual Residence Communication	11 of Decedent	6. Sex 1 □ M 2 X F	7. Age (In yrs. Ia	st birthday) Yrs.	If Unde Months	Days	Hours	24 Hrs. Min.	8. Date of Birti (Month, Day 04/05/	, Year)	3	Count	lace (State or Foreign ry) nington, DC
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ould be deta	þ	Part II. Other signifi	icant conditio	ons contributing to d	seath but not resu	Iting in the	underlying	cause giv	en in Part	1.					cause of death?
completely filled in by the funeral director, page 2 should be detached	Completed										24a. Was a autop: perfor 1 Yes	sy med? /	pri de	ere autops for to corr ath?	sy findings available pletion of cause of
director	To Be	25. Was case referre examiner? 1 Yes 2		Hospital:	Inpatient 2 🗆 E	R/Outpatie	nt 3 🗆 D0	Otho	ce of Dear		only one) me 5 ☐ Reside	ence 6	S ☐ Other	(Specify)	
the funeral	Certificate:	27. Manner of Death 1 □ Watural 2 □ Accident 3 □ Suicide	5 Pendir Investiç 6 Could	gation	th, Day, Year)	28b. Time o injury	М		at	2	8d. Describe ho				
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mpletely f	Medical	(Check 2 only one) 3	 Medical E □ Certifying 	Physician: To the be xaminer: On the bas Nurse Practitioner	sis of examination	and/or inves	tigation, in a	my opinior urred at th	n, death oc e time, dat	ccurred at	the time, date an ce, and due to th	e cause	, and due t e(s) and ma	o the caus	se(s) and manner stated. ated.
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	Physicia Medi		FRANK	ALDEN HUN	TSMAN			2. Date of De Month	eath Day	28 201	3. Time of Death
	Examir	ier	4a. Facility Name (if not institution, give	· ·			vn, or Location of	Death	/ 4c.	County of Death	
	Funeral		Meritus Medical 5. Social Security Number 6. S		e (In yrs. last birthday)	If Under 1	gerstown Year If Under 2	4 Hrs. 8. Date of Bir	th.	Washing	hplace (State or Foreign
	Director		514-18-5093 Usual Residence of Decedent	∑ M 2 □ F	87 Yrs.	Months D	ays Hours	Min. (Month, De Feb. 21	, Year) , 192	25 South	intry) Kansas
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Maryland	0 ± 0 0	To E	Wayne Leon Hun	tsman			18. Mother	s Name (First, Middle, 1 Louise		Surname) ullen	_ .
Mai	ge 1 and 2 should be nt of Health and Men if item 27 is marks or other traumatic		19a. Informant's Name/Relationship (7)					or Rural Route Numbe			,
	permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other t		Valli Ritchie/st 20a. Method of Disposition	ep-daugnte	20b. Place of Dispo			Madison H		cation - City or 1	
Baltimore,	age 1 ent of nt: If i		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific	Removal from State	cemetery, cren	natory or other	place)	y 31,2012			, Maryland
alti	permit. Pa Departmer Important any injury once.		21. Signature Juneral Spirite Access	eg/			ddress of Facility			in Stree	
m	e a E c e	Ш	V101901111. Vs	la	Ri	icketts	Funeral			ille, MD	
200	Physician/ Medical		23a. Part 1 Enter the disease, or company shock, or heart failure. List only old Immediate Cause (Final disease or condition resulting in death)	a. Re	. , , , , , , , , , , , , , , , , , , ,	the mode of	dying, such as ca	rdiac or respiratory an	rest,		Approximate Interval Between Onset and Death
	Examiner		Cognostially list and distan-	b							2 weeks
	uted d ansit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	be executed sician and burial-transit	al Ex	that initiated events resulting in death) Last	Due to (or as a	consequence of):						
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. Box 687	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burial-transi		F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live Birth 1/2 4 ☐ Pregnant at g ☐ Unknown	2 Fetal death 3	Ectopic pregi Other (specif	nancy .y)		2	23d. Date of deliv	very Day Year
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ds,	quires en sign ould by	edk	Demen	tia	-			1 🗆 '	Yes 2	o 3 ☐ Pro	bably 4 - Unknown
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Re	The la	8						_ perfo	rmed?	death?	_
ta	sician: The certificate irector, pag	Be	25. Was case referred to medical examiner?	Hospital:			6. Place of Death	(Check only one)			
Į V	Phys this c	<u>و</u>	1 Yes 2 No	1 Inpatie	nt 2 ER/Outpatien v 28b. Time of	t 3 🗆 DOA	Other: 4 Nurs	ing Home 5 Resid			<u>v)</u>
ou o	ending F eath. or: After the funer	Certificate:	1 Natural 5 ☐ Pending 2 ☐ AccidentInvestigation	(Month, Day,		\ \	njury at work? 1 ☐ Yes 2 ☐ N	28d. Describe h	iów injury	occurred	
Division of Vital Records,	al or Att. s after de al Directo	Certi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, stre (Specify)	et, factory, offi	ice	28f. Location (S City or Tow		Number or Rura	l Route Number,
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director. Af completely filled in by the fu	Medical	(Check 2 L. Medical Exami	ner: On the basis of ex	ny knowledge, death o amination and/or investi best of my knowledge,	gation, in my o	pinion, death occu	rred at the time date a	nd place	and due to the ca	ause(s) and manner stated
	To the within to complete the c		29b. Signature and title of certifier			29c. Lice	ense number		29d. Date	e signed (Month.	Dav. Yearl
			1 BKen	-2-		2	3847	7 /	57	129/10	
	p/		30. Name and address of person who c	ompleted cause of de	ath (Item 23a) (Type, Pr	int)	Rlus	5-156	- 6	h-	
	Ctot	2	William Kerns 11. Date filed (Month, Day, Year)	32. Re 14ar	's Signature	crson	121001	Veril IN	,00,	2 19.	<u>ی</u>
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			1 - State Registrar 1. Decedent's Name (First, Middle, La		of Marylar			nt of H te of L			Al Hygie Reg	1	012	3. Time of) 6 3 Death
	Physici		Hazel Mae Jones							0.5	enth	17	2012	9:34	a_{M}
>	/Medic Examin		4a. Facility Name (If not institution, given	e street and nu	mber)		4b. City	, Town, or	Location of De	ath		4c. Cou	nty of Death		
			1008 Riverhouse R	d., Apt.	6			isbury	/				comico		
	Funeral Director		263-64-1408	Sex I□M 21 <u>C</u> 1MF	7. Age (In yrs. 70	last birthday) Yrs.	Months Months	Days	If Under 24 H Hours Mi	n. (Mo	te of Birth onth, Day, Y 19/194	ear)	9. Birthp Coul Flor	olace (State of ntry) ida	r Foreign
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							0d. Inside Cit	ly Limits
	f eho	JO.	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	_	0-1									1 🗆 Yes	2 🗌 No
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	With With		1008 Riverhouse R	oad. Ap	t. 6		21	801				USA			
	death	Funerai	11. Marital Status	-	edent Ever in U	J.S. 13.	Was Dec	edent of Hi	spanic Origin? n, Mexican, Pu	(Specify Ye	s or No-	14. F	Race - Americ		
õ	or Ite	/ Fu	1 ☐ Never Married 2 🔀 Married	1 ☐ Yes If Yes, Gi	2 🔯 No ve	i	1 □ Yes		Specify:	orto modifi,	010.)				
ğ	ural',	d by	3 Widowed 4 Divorced	Year or E	Dates:	,					10		Blac		
7	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f ehow ent, the Macisal Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gr	ducation ade <i>completed)</i>		16a. Dece (Give	dent's Us kind of w DO NOT	uai Occupa rork done d use retired	ation during most of w)	vorking	16	b. Kina o	f Business/In	dustry	
212	withi ene. then	ошь	Elementary/Secondary (0-12)	College (1-4or 5+)				ng Assis		1	Hospi	tal		
Maryland 21215-0036	Hyg other	Be C	17. Father's Name (First, Middle, Las)		1			18. Mother's N		Middle, Ma	iden Sum	name)		
<u>a</u>	uld be Menta Menta irked ific e	To B	unknown						Fran	ces K	nowles	3			
<u>a</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Examinat must be notified at angle.		19a. Informant's Name/Relationship	Type, Print)		19b. Maili	ng Addre	ss (Street a	and Number or	Rural Route	e Number, C	ity or To	wn, State, Zip	Code)	
	and ealth m 27 her tr		Doris Turner/ cous	in	1005	228 Place of Dispo			C Dr., A	Apt. G					04
0	Pages 1 nent of H int: If Ite iry or ot		20a. Method of Disposition 1 □ Burial 2 【*** Cremation 3 [State	cemetery, crei	matory`or	other place	1				on - City or To		
Baltimore,	rtmen rtant: njury		4 ☐ Donation 5 ☐ Other (Special Service Lice		Sa	lisbury							ry, Ma		
Ba	permi Depa Impo any it		21. Signature of Furieral Service Lice	1500	400	7			s of Facility 12 EMORIA		-	toau,		1801	עו
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O. Box 6	The law requires that the death certific ate has been signed by the atlending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live	itcome of pregni birth 2 Feta nant at time of c lown	al death 3	⊒Ectopic ⊒ Other (:	pregnancy specify)					Date of deliv Month	,	Year
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ğ	w require been sig should b	ed t	Hypore	mia						-	1 🗆 Yes	2 🗆 No	o 3 Pro	bably 4 □U	Jnknown
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ř		Com								1[performe ☐ Yes 2 ☐		death? 1 ☐ Yes		
<u>I</u>	cian: ertific actor.	Be (25. Was case referred to medical examiner?					100	26. Place of E	eath Chec	ck only one				
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ב	After After funer	lon	27. Manner of Death 1 Natural 5 Pending	,	of injury oth, Day Year)	28b. Time o Injury	M	28c. Injury Work	/at <br Yes 2 ∐No	28d. D	escribe how	injury oc	curred		
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not to determined	e 28e. Plac	e of Injury - At h ling, etc. (Speci	ify)			163 2 100		cation (Stre ty or Town,		umber or Run	al Route Num	ber,
	Hosp. 4 hou Funer ely fill	edicai	29a. Certifier 1 ☐ Certifying P (Check only 2 ☐ Medical Exa	miner: On the b	pasis of examina	owledge, deat ation and/or in	h occurre	d at the tim	ne, date and pla pinion, death o	ace, and du ccurred at th	e to the cau he time, date	se(s) and and place	manner as s	tated. o the cause(s	;)
	thin 2 the mplet	Med	one) 29b. Signature and title of certifier	and mar	ner stated.		-	9c. License					gned (Month,		
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	20	/	39. Name and address of person who	completed cau	se of death (Ite	m 23a) (Tune	Print)	100	30614			0	1/21/	2011	
	0		//	Mr MD	10.00	m 23a) (1ypo, Cryber hu	~ E	x 8	N614	Sal	1) b	m	318	2)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND 24A, 25,27 PER MD 6929 7 5/12 TRT Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ 2012 zabeth Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wicomico Peninsula Regional Medical conter 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) 24 Hrs. **Funeral** 2018-92-1625
Usual Residence of Decedent 68 Director 1 - M 2 X F 8-31-1943 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No ccomack 10e. Street and Number 10g. Citizen of What Country? Funeral 3336 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 Married 1 ☐ Yes 2 Mo If Yes, Give Year or Dates. 1 Yes 2 No Specify. 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ည H Jester Harvin Virginia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Num er, City or Town, State, Zip Code) Jester Miriam 20a, Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 5-16-2012 lemperanceville, UA Taylor Cometer 21. Signature of Funeral Service Licensee hincoteague, VA 2333 22. Name and Address of Falility Homz, Inc Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No should be detached for Day Month Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed' 2 🗌 No Yes 2**X** No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Certificate: To I 2 **X** No 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending work? Accident Suicide 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d, Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 27 Er Cosmil 31. Date filed (Month, Day, Year) State MAY 1.5 Registrar

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	ro the vithin го the го the го тре		only one) 3 ☐ Certifying Nu 29b. Signature and title of certifier	rse Practitioner: To	o the best of my I	knowledge,	death occurred at the 29c. License		nd place, and due to		e(s) and manne ate signed (Mo		
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	Stat Registra	e	31. Date filed (Month, Day, Year)	0112 32. Feg	istrar's Signature								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <u>3</u>0 Day Physician/ May Camillus Carrico Kirk Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death **Examiner** Ceci1 220 Park Circle E1kton If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In vrs. last birthday 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Days (Month, Day, Year) 214-03-0837 Director 1 👿 M 2 🗆 F JAN 22, 1921 Maryland Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 X Yes 2 No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21921 220 Park Circle United States 12. Was Decedent Ever in U.S. Armed Forces? World 1 X Yes 2 No If Yes, Give War II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify Specify: White 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Meat Cutter Grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Wilmer N. Kirk Florence Cooke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other traignes. Anne W. Kirk/Wife 220 Park Circle, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 🗓 Cremation 3 🗆 Removal from State R. A. Ferris & Co., Inc. West Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) 2012 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events Due to or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes No Z ္ပင 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? نه 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending Certificat 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within To the 29b. Signature and title of certifier of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Richard Wayne Layfield 1526 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional medical center Wicomico Salisbur Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Hours (Month, Day, Year) 219-60-0304 Director 1 🕱 M 2 🗆 F 57 May 30, 1954 Maryland 28a-f shov 10c. City, Town or Location 10d. Inside City Limits Director must be notified DE Sussex Delmar 1 XX Yes 2 No. 10e. Street and Number ь 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 501 E. Jewell Street 19940 U.S.A. 11. Marital Status Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Force Yes, specify Cuban, Mexican, Puerto Rican, etc. 0 Black, White, etc. 1 Never Married 2 Married 2 XX No and 2 should be filed within 72 hours after Yes 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 🗆 Widowed 4 🗆 Divorced Specify: white Year or Dates er than "natur , the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other t 8 electrician electrical Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Health and Mentatem 27 is marked the traumatic e Richard Lee Layfield Mardella Gertrude Bolen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Jean Layfield (Wife) 501 E. Jewell Street Delmar, DE other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or oth once. Page 1 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 5-15-2012 Delmar, Delaware Signature of Funeral Service Licenses 22. Name and Address of Facility
Short Funeral Home
13 E. Grove Street ew el Delmar, DE 23a. Part 1. Enter the disease, or complice shock, or he it failure. List only one ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause Physician/ ARDIOLENIC SHOCK disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury MICVE burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician thed for use as the buria Be Completed by Physician/Medical Box 68760 detached for use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day · by ı P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔊 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 N Division of Vital filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 2 1 Yes 2 📝 No 1 Inpatient 2 RER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After the Hospital or Attending 1 Natural 5 Pending injury work?
1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 06-2011

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Carroll

Street

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May Month 20\f2 Carmela Lagano McGough 0100 Ам . Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Hospital E1kton Ceci1 Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Days Hours Min July 23, Year) New York 80 **Director** 216-28-6615 Usual Residence of Decedent show or 28a-f shov be notified at filed within 72 hours after death with the Maryland al Hygiene. al Hygiene. d other than "natural", or items 23a or 28a.4 ehm 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 😾 No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 3 Malvern Drive 21921 United States items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) n "natural", or item fedical Examiner n 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 Divorced Specify: Completed Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done durina most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Executive Secretary Aerospace Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H
27 is marked of
real traumatic ever permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve Pasquale Lagano, Sr. Mary Macchio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carmela A. Texiera/Daughter 3 Malvern Drive, Elkton, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Delaware veteralis Memorial Cemetery Mav 2012 Bear, DE 22. Name and Address of Facility Hicks Home for Funerals, P.A. Signati e of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death etastatic Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examine Sequentially list conditions, if any Leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to lor as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): resulting in death) Last been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate has completed filled in by the funeral director, page 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗹 No Certificate: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after death Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the Within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Jackder SMD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SS 8ACHDEV MD, 126 A. E. Huel.

Registrar

State

Elbton MD21921

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/Medic		4a. Facility Name (If not institution, g		-	<u> </u>	4b. City, Town, or	Location of Death		4c. County of Death				
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or 28g	Director	10e. Street and Number			 	10f. Zip Code			10g. Citizen	of What Cour	itry?		
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ges 1 and 2 should be filed within 72 hr t of Health and Mental Hygiene. If item Z7 is marked other than "natu or other traumatic event, I'r o Medical		Danyel Meadows/				ocust Poi			-	21921	,		
s 1 au of Hez item		20a. Method of Disposition		20b. F		osition (Name of matory or other place		Date 29,		on - City or To	wn, State		
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death ctor: y the	ficat	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could no	t be	e of Injury - At he	ome, farm, st	reet, factory, office	Yes 2 □ No	28f. Location (Street and N	umber or Run	al Route Nur	nber.	
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, go	edical C		kaminer: On the t			th occurred at the tinvestigation, in my o						s)	
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1./		30. Name and address of person w	necompleted cau	se of death (Iter	n 23a) (Type		n n	MD 10	, A.	11	EIK	tan	
V		31. Date filed (Month, Day, Year)	0010 32	legistrar's Signa	ature /	a del	inn,	mu /6	1000	W 3/.	n.s	3192	
Registra	ar	JUN 0 6	2012 🔑	run 1	4. H	0							

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month Physician/ Mary Carmela Shandor Mav 3:19P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Pennsylvania Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8 Date of Birth Hours 1 □ M 2 👿 195-22-3927 Director 84 Usual Residence of Deceden ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Cambria 1 X Yes 2 No Penn. Cresson 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 309 Ashcroft Ave. 16630 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ð 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 X Widowed 4 □ Divorced Completed Year or Dates 15, Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Gaetano Albarano Maria Grazia Macchiarulo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Shandor/Son 3267 Breckenridge Way, Riva, MD 21140 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Remoral from State Arlington Nat'l Cem Arlington, Virginia 5 Other (Specify) 4 Donat unk 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatur 2973 Solomons Island Rd., Edgewater, MD 21037 Part 1. Enter the disease, or complice shock, or heart failure. List only one ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Onset and Death Physician 0 disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the attending physician and the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown been signed by the atte Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Whitnown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? after death.

Director: After this certificate I 1 Yes 2 No 2 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗆 6 Other: 유 1 Dopatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) . Manner of Death 1 Hatural 2 Accident Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 \sum Yes 2 🗌 No Investigation 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical critifying Physician: To the best of my knywledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examplation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Gertifying Nurse Practioner: To the b of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the

Registrar

0,

Signature and title

30. Name and address of person who completed pause of death (Item 23a) (Type, Print)

0

29d. Date signed (Month, Day, Year)

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND 24A & 27 PER MD G928 6/27/12 TRT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Arthur Sturgis, Sr. 2012 1:07P^M 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 10546 Harrison Road Berlin Worcester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 □ F 85 Yrs. Director 222–16–2471 Usual Residence of Decedent Berlin, 12/27/1927 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any finury or other traumatic event, If a Modified Evanciated in a Linked at any finury or other traumatic event, If a Modified Evanciated in the Indified at appreci 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10546 Harrison Road 21811 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 XNo Specify þ Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Worcester County College (1-4or 5+) 9th School Bus Contractor Board of 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) John West Purnell Hester Sturgis Nichols ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Constance Sturgis 10546 Harrison Road, Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Bethel UMC Cem 5/19/2012 Berlin, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1618 West RD Lewis N. Watson Funeral Home, PA SAlisbury,
Approximate 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial lutarction /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a nonsequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and burial-trai Due to (or as a consequence of) Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No P.0. 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ DM 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate perform Division of Vital 1 ☐ Yes 2X No 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending death. ne Hospital or Attendi 24 hours after death. ne Funeral Director: A 2 Accident investigation 1 Tyes 2 □ No Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number angela Gilly VID 5/15/12 D0066169 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TC Arcela Gibis MD, 10445 old Ocean City Blue #11 Berlin, 410 21811 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar DHMH IT Bachdooti

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William Hamilton Smith 10:25 pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice sburu Wicomic Age (In 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F 214-16-4756 Months Davs Hours Min Director Maryland Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Maryland Wicomico Parsonsburg 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral items 23a 21849 USA 6132 Sixty Foot Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, rmed Forces?

X Yes 2 \(\sum \) No Black, White, etc. and Mental Hygiene. is marked other than "natural", or 2 1 Never Married 2 X Married アレバルス・イ・ング・アのBaltimore, Maryland 21215-0036 If Yes, Give Year or Dates Army 1 ☐ Yes 2 🗙 No Specify: Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Automotive Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ္ William Dale Smith Nannie Mae Green injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Jo Smith/Wife mportant: If item 27 6132 Sixty Foot Rd., Parsonsburg, MD 21849 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State of 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Parsons Cemetery 5/16/2012 Salisbury, MD 21. Signature of Funeral Service 22. Name and Address of Facility
Holloway Funeral Home Professional Association any Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) -transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) burial physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 ģ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should been Were autopsy findings available prior to completion of cause of 24a. Was an certificate 1 Yes 2 1 Yes 25. Was case referred to edical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this 27. Manner Teath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending **L** atural injury work?
1 Yes s after death. 2 🗌 No Accident Investigation 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) ss of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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AMEND ITEM#22perfH, G929, 7/27/2012, WS
State of Maryland / Department of Health and Mental Hygiene
AMEND ITEM#17-19h, perfH, G931, 9/10/2012, WS

Certificate of Death

Reg. No. 2012 State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Frederick Smalls 05 0223 M 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional Medical alisbun Wiconico Center If Under 24 Hrs **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Months Days (Month, Day, Year) Director 150-58-7474 1 🔀 M 2 🗌 F Yrs New Jersey 01/02/1963 Usual Residence of Decede or 28a-f show 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Dorchester Cambridge 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 701 Race Street - 411 21613 USA death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. <u></u> 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Never worked n|a marked other 1 and 2 should be filed w of Health and Mental Hygi item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental I 7 is marked of Fred Smalls 2 Gayle Ashwood eatrice Victoria Green 19a. Informant's Name/Relationship (Type, Print) b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) PO Box 16186, St. Petersburg, FL 33733 Cayle Ashwood/Mother kathaleen Artybooker/Sister 20a. Method of Disposition permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other toonce. 3008 Huntley St. Spring Lake, NC 28390
Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Anatomy Gifts
Registry ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/15/2012 Hanover, MD Anatomy Circs Registry Heme Professional Association Y. / Sarisbury, MD 27004, MD 21076 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens ame and Address of Facility A Kell K flery 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph₁ sician Onset and Death Accident Cevetrovasenter disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Hypertensin Sequentially list conditions, Examine if any, leading to immediate Due to (or all a consequence of cause. Enter Underlying Cause (Disease or injury burial-tra that initiated events resulting in death) Last Due to (or as a consequence of): ed by the attending physician detached for use as the buria Physician/Medical Box 68760 as the IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 4 Pregnant 5 Other (specify) Month Pregnant at time of death Day Year g Unknown P.O. ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? this certificate 2 🗆 No 2 1 N Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: he Hospital or Attending Pin 24 hours after death.
he Funeral Director After the pletely filled in by the funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred ✓ Natural 5 Pending work?
1 Yes 2 No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 L 3 L To the l within 2 To the l Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 268222 22 05/14/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Afza Carroll Street Salisbury MD 2180 Raza MD 100 31. Date filed (Month, Day, Year) State 32. Registra 's Signature back Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 7:05 P Marie Elizabeth Stewart Mav Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Devlin Manor Health Care Center Cumberland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🛣 F Months Days Hours Min. 03/13/1949 63 Yrs. **Director** 220-54-4219 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits Examiner must be notified at Director 1X Yes 2 ☐ No MD Washington Hancock 5 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 21750 140 East Main Street items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 0 þ 1 Never Married 2 X Married 1 Yes 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Specify: White Completed 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thelma Geraldine Clingerman Carl E. Wertman, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trains 140 East Main Street Hancock, MD 21750 Talmadge Oakley Stewart/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/15/2012 | Artemas, PA Fairview Cemetery 22. Name and Address of Facility 141 West Main Street Signature of Juneral Service Grove Funeral Home, P.A. Hancock, MD 21750-0368 MO0260 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) mura Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No for Month Dav Year Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed 2 No Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🗌 Yes 2 - No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 5 Pending injury Halfiral s after death.

I Director: Af 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Funeral D Medical 29a. Certifier 1 - Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 | Medical Examiner: Of the basis of examination in resugation, it is a stated.
3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 **To the I** 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) May 12, 2012 D0017565 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 62 Vale, no 21502 73:11 ino NEFI

State Registrar 31. Date filed (Mon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Jean 0352 2013 Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death **Examiner** JuliaMewor ealtho Washington Hagerstown If Under 1 Year | If Under 24 Hrs. . Social Security Number 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) (Month, Day, Year) 215-42-4075 Director 1 🗆 M 2 🔀 F 67 Maryland 10/12/1944 28a-f show Examiner must be notified at 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Hagerstown Maryland Washington o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral U.S.A 21740 333 Mill Street 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, than "natural", or 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 X Widowed 4 □ Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Domestic Homemaker is marked other should be filed v and Mental Hyg 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bender Itnyre Ruth Jane Mills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health item 27 307 Radcliffe Ave Hagerstown, Maryland 21740 Jeanie Anderson/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl 1 Burial 2 X Cremation 3 Removal from State Smithsburg Crematory 6/1/2012 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Maryland 21. Signature of Funeral Service Licensee

5. Mall Sun 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown, Maryland 21742 23a. Part 1. Enter the disease, or conflications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed -trar resulting in death) Last Due to (or as a consequence of) Physician/Medical utia with Depression Division of Vital Records, P.O. Box 68760 IF FFMALE. 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 2 X No Unknown 9 Unknown signed by t Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Peripheral Vascular Disease, Multiple CVA'S 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hypercholesterolemia, COPD, GERD 24a. Was an ate has t autopsy 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 💢 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: / 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific Name and address of person who completed cause of death (Item 23a) (Type, Print Borbara Nader-Blucker CRNP 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ May 2012 Patricia Stella Smith 28 0630 Αм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Union Hospital Elkton Ceci1 Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Days Hours Min. NOV 8, 1944 **Director** 217-50-2011 67 Maryland Usual Residence of Decedent 28a-f show 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 102 Mallard Court 21921 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🔀 No Specify: 3 🕅 Widowed 4 🗆 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed witl Department of Health and Mental Hygier Important: If item 27 is marked other 1 any injury or other traumatic event, the Inspector Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edgar E. McMillan Rose Harmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Sizemore/Daughter 784 Shady Beach Road, North East, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State May Date 9. 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) R. A. Ferris & Co., Inc. 2012 West Chester, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exam sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): tending physician a Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery 1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown in the past 12 months?
1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Vulmonary I Tease 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\sum \) No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number,

Box 68760 P.O. I Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Division of Vital completed filled in by the funeral

Registrar

Medical

29a. Certifier

(Check

29b. Signature and title of certifier

Tolder S. MD

84CHDEN MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

126 A, E tagh

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

10023322

Elkton MD2/901

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Day Month Kowena 0902 AM 2012 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Ummo Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year) 216-14-9703 Director 88 Nov. 28, 1923 Maryland 28a-f shov 10c, City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1XX Yes 2 ☐ No Wicomico Fruitland 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? 23a Funeral 21826 114 N. Brown Street U.S.A. items death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, or þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 XX No 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: than "natural", 3 Widowed 4 Divorced white Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. 12 office assistant hardware store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Elton Thomas Butler Ella Grace Kee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health item 27 4472 Sturbridge Drive Department of Health Important: If item 27 any injury or other tr Sandy Riley (Daughter) Salisbury, MD 21804 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 K Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crematory of Delmarva May 14, 2012 Delmar, Delaware Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home Grove Street Delmar, DE 23a. Part 1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Phylician/ disease or condition Medical AND THE DICK CHAMES resulting in death) Examiner Sequentially list conditions, Examiner If any, leading to in module cause. Enter Underlying Cause (Disease or injury that initiated events law requires that the death certificate be executed burial-trar Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Day Year Pregnant at time of death 9 Unknown Linknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No page or Attending Physician: The 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
Yes 2 \sum No Other: 4 Nursing Home Hospital م Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 5, 8, 2012 28b. Time of Certificate: 28c. Injury at injury Un Knewn Natural
Accident 5 Pending work' 1 Yes 2 No Trip Oxygen the Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide filled in by determined within 24 hours af

To the Funeral D

completely filled i 114 N. Brown To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title certifi 101386 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Greene St Baltimore MD vectel 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Richard Lee Taylor 0700 Medical $\Delta \omega$ 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death isbury Rehabilitation & Nursing Cti lisbu Dicomico If Under 1 If Under 24 Hrs. **Funeral** 7. Age (In vrs. la) 8. Date of Birth 9. Birthplace (State or Foreign 220-26-8842 1 🕱 M 2 🗆 F Months Min. 08/08/1932 79 Maryland Director Usual Residence of Decedent show 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits notified at Director 28a-f 1 Yes 2X No Maryland Wicomico Salisbury 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 1303 Hazel Street 21804 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural". or item—any injury or other trainmatic. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 🗶 No Specify: White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Worker Auto Dealership Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Wilson Straughn Taylor Sr. Virginia Hitchens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1303 Hazel St., Salisbury, MD 21804 Joanne L. Taylor/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) Salisbury Crematory 5/15/2012 Salisbury, MD Signature of Fune a Se Ac 22 Holloways Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Domoson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner signed by the attending physician and d be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? [≥ 1 Yes 2 No 3 Probably Munknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy perforn death? director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 🗌 No 2 ☐ Âccident 3 ☐ Suicide 4 ☐ Homicide Accident Investigation within 24 hours after death To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and titl address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

2612 Registrar's Signature

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		•	State Registrar		,		Certificate of I	Death	,	Reg. No.	
	Physicia	ın/	1. Decedent's Name (First, Mic						2. Date of De	ath	3. Time of Death
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	Examin	er	4a. Facility Name (if not institut			. 0	4b. City, Town, o	. 1	Death /	4c. County	of Death
	Funeral		Salsburg Red 5. Social Security Number	6. Sex	7. Age (In vrs.	last bythd	av) If Under 1 Year	If Under 24	Hrs. 8. Date of Bir		9. Birthplace (State or Foreign
	Director		217-36-2010	1 X M 2 □ F	88	Yr	Months Days		Min. 08/16/	y, Year) 923	Country) North Carolina
,	, MC		Usual Residence of Decedent						100/ 20/ 2		THOSE CIT COST STATE
	yland -f sho ed at	ţō	10a. State 10b. Cour	•		City, Town o					10d. Inside City Limits
	e Mau r 28a notifi	Ë	Maryland Wic	omico		Salisk					1 🕱 Yes 2 □ No
	ith th	ral	200 Civic Av	_			10f. Zip Code			10g. Citizen of V	What Country?
	ems ?	Funeral Director	11. Marital Status		cedent Ever in U	J.S.	2180		n? (Specify Yes or No-	USA	e - American Indian.
D	or it		1 Never Married 2 N	Armed F farried 1 X Yes	orces?		13. Was Decedent of H If Yes, specify Cuba		Puerto Rican, etc.)		ck, White, etc.
23.5	ırsafi ural", IExa	ed	3 🕱 Widowed 4 🗌 Divorc	ed If Yes, G Year or I	olive Army		1 ☐ Yes 2 🛣 No	Specify:		Specify:	White
3-0-5	"nati	plei	15. Dece (Specify only hig	dent's Education ghest grade completed	d)	16a. D	ecedent's Usual Occup	ation during most o	f working	16b. Kind of Bu	usiness Industry
Maryland 21215-003	thin 7	Completed by	Elementary/Seconday (0-12) College ((1-4 or 5+)	Ìifi	e. DO NOT use retired)	y	· · · · · · · · · · · · · · · · · · ·		
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aryland	be fil lental rked ic ev	욘	Leslie Benja						ie Lee Tha		
a S	hould and N s ma umat		19a. Informant's Name/Relatio		-	19b. N	failing Address (Street				
	id 2 sealth an 27 i		Bryan Twigg/S	on)l Pacific				
BE (of He of He if item		20a. Method of Disposition 1	n 2 Domesial from	20b.	Place of D	isposition (Name of	re)	Date	20c. Location -	City or Town, State
(X) Ē	Page ment tant: I		4 Donation 5 Other		m State Sp	ringh Garde	crematory or other place nill Memory ens	5	/22/2012	Hebron	, MD
\mathcal{B}_{ef} Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Lime	(F)x-	2	22. Name and Addre	s of Facility uneral	Home Prof	essiona	l Association
			23a. Part 1. Enter the disease, shock, or heart failure. Lis	or complications that	caused the dea	ath. Do not					Approximate
	Physician/		Immediate Cause (Final disease or condition		ilure	7	Their	118			Interval Between Onset and Death MOWALES
	Medical Examiner		resulting in death)	ntie							
		<u>_</u>	Sequentially list conditions,	b. Ch	ed S	tag	L De	me	ntia		Glars
	sit of	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Dure to	(ur as a consec	quence 🗸 :					/
	ecute and I-tran	Exar	that initiated events resulting in death) Last	c. Due to	o (or as a consec	uence of):					
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8760	tificate be ng physicia as the bur	ledi		d							
9	snding use 8		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	utcome of pregn	ancy	3 Ectopic pregnance			23d. Dat	te of delivery
Вох	requires that the death cer been signed by the attendi should be detached for use	Physician/	in the past 12 months? 1 Yes 2 No	4 ☐ Pre	gnant at time of	death	5 Other (specify)	у		Mot	nth Day Year
	of the	된	9 ☐ Unknown Part II. Other_significant co n di			audžina ir št		- P- II	- 1	,	
σ.	requires that the been signed by the should be detach	à	Cardi	EVIL 16	death but not re	tie	ie underlying cause giv	en in Fait i.			ibute to the cause of death?
50	requir	etec	G+.	an l	10	7/2		4			3 Probably 4 Unknown
Division of Vital Records,	e law has b	Completed by	Jures	- Jun	76	HEI	nepar	exes	— 24a. Was a autop	sv p	Vere autopsy findings available prior to completion of cause of leath?
Œ.	n: The ficate or, pag		25. Was case referred to medical						1 Tes		Yes 2 No
/ita	rsicia s certi directe	To Be	examiner?	Hospital:	lamationt 2	TD/Outra	atient 3 DOA Othe	r.	Check only one)		
of	g Phy erthis neral o		27. Manner of Death	28a. Date	e of injury orth, Day, Year)	28b. Time	e of 28c. Injury	at	ng Home 5 Resid	ow injury occurre	
on	endin eath. or: Aft he fur	ficat		stigation	ntri, Day, rear)	injur		? Yes 2□No	0		
VİSİ	r Atter de irecte	Certificate:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide deter	mined 28e. Place	e of Injury - At h ling, etc. (Specif		street, factory, office		28f. Location (S City or Tow		r or Rural Route Number,
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:	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has I completed filled in by the funeral director, page 2 s	Medical	(Check 2 ∟ Medica	I Examiner: On the ba	sis of examination	on and/or in	th occured at the time, vestigation, in my opinio	n, death occur	rred at the time, date as	nd place and due	to the cause(s) and manner stated
:	o the vithin o the comple		only one) 3 L Certifyii 29b. Signature and title of certifi		to the best of m	ny knowledo	ge, death occurred at the				nner as stated. (Month, Day, Year)
	->=0		Leona.	Z. Kol.	Por a	M		950			17-2012
	270		30. Name and address of perso	n who completed cau	se of death (Iter	n 23a) (Typ		- (4)			
	IVA		GREGORIO					RRY	DR. SALIS	BURY, 1	MD 21801
	Stat Registra	~	31. Date filed (Month, Day, Year)		Registrar's Signa		backer				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh 9928 6-22-12 vt
State of Maryland Poepartment of Health and Mental Hygiene for State Registrar 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{Day} 2012 Harry W. Thomas May 30 0950 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll County General Hospital Westminster Carroll 5. Social Security Number **3364 161–20–3064** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours **Director** 1**X** M 2 □ F 85 Nov. 26, 1926 Maryland Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 🗆 Yes 2😾 No Baltimore Sparks 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16640 Cedar Grove Road 21152 U.S.A. or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: "natural", 3X Widowed 4 □ Divorced Completed White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the Manaley injury or other traumatic event the Manale Elementary/Secondary (0-12) College (1-4 or 5+) 8 Foreman Electric Company Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Harry N. Thomas Dorothy Wirtz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Thomas/Son 1263 Emerald Ridge Dr Westminster, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Cedar Grove Place) United Meth. Cem 1 X Burial 2 Cremation 3 🗌 Removal from State June 2012 Donation 5 Other (Specify) Cem. Parkton, 22. Name and Address of Facility JJ Hartenstein Mortuary, ture of Funeral Service Inc 24 N. Second St. New Freedom, PA 17349 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause an each line Interval Between Immediate Cause (Final Ons and Death Physician/ nendecatis disease or condition resulting in death) Medical (or as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): and I-transit Exami pirato executed that initiated events Due to (or as a consequence of) resulting in death) Last -burialphysician s the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ jo in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 1 Yes 2 L 9 Unknown the Unknown signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed' certificate 1 Yes 2 No Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes 잍 this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural (Month, Day, Year) 5 Pending work? 1 🔲 Yes after death. Director: At Accident М 2 🗌 No Investigation the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check within 2 To the I 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of pers n who completed cause of death (Item 23a) (Type, Print 2115 Wille 31. Date filed (Month, Day, Year) 32. F State Registrar

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 Phy M Exa To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Division of Vital Records, P.O. Box 68760

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Funeral		5. Social Security N	umber	6. Sex	7. Age (n yrs. last birthday		rIf Under		8. Date of Bi				lace (State or Foreign
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director		tockto	n Road			10f. Zip Code 218				_	Ditizen of Wh	at Coun	try?
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To the Hospital or Attending Physician: The law requires that the death certificate be exe within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician is completely filled in by the funeral director, page 2 should be detached for use as the burial	Medical	(Check 2	Medical E	xaminer: On the I	basis of exam	nination and/or inve	occurred at the tin stigation, in my opir e, death occurred at	ion, death oc	curred at t	the time date a	and place	e and due to	the caus	e(s) and manner stated
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State

Registrar

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31. Date filed (Month, Day, Year)

michael Justin Vannostrand 12-03615 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene · Unk Unk 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day May 11, 2012 0025 hrs **Medical Examiner** Michael Justin Van Nostrand 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Prince Frederick 100 Solomons Island Road South Calvert If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days Hours Director 214-23-0290 9/5/1982 S.C. 1X M 2 F 29 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No MD Calvert Dunkirk permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygien. Department of Health and Mental Hygien. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she Injury or other traumatic event, the Medical Examiner must be notified at once Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10320 Wild Goose Way 20754 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 2 X No 1 Yes 1 Yes 2 X No specify: 3 Widowed 4 Divorced If Yes, Give Year White \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Heating and Air Baltimore, MD 21215-0036 HVAC Mechanic 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kathy Hardiman Stuart Van Nostrand 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10320 Wild Goose Way, Dunkirk, MD 20754 Kathy Steinitz/Mother 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 5/31/12 Beltsville, MD Chesapeake Crem. 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Raymond-Wood F.H., Dunkirk, MD 20754 PO Box 430, 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death Immediate Cause (Final disease a No Anatomic or toxicologic cause of death Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): sician/Medical AMENDED 23a, 27, 28a-f, per me, g930 8-9-12 sm X UNPENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, P.O. 5 1 Yes 2 No 3 Probabiy 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed' 1 🗸 Yes 2 No ✓ Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical 8 Other Nursing Home 5 Residence 6 🗸 Other: Scene Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Division 1 Yes 2 X No 5 Pending unknown fd 5-10-12 | fd 22:30 pm 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 X Could not be or Town, State) 100 Solomons Island Vacant Building determined South Prince Frederick, MD 4 Homicide 29a. Certifier 1

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in 99 the funeral director, page 2 should be detached for use as the burial - transit completely filled in 99 the funeral director, page 2 should be detached for use as the burial - transit

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) OCME

O.C.M.E

May 11, 2012

Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Theodore M. King, Jr., MD.

State Registrar

Medical

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			1 - For State Registrar	State of Ma	aryland /		artmen <i>tificati</i>			and Me		giene Reg. No	6016	179
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	rysici. Medic		Melvin Fugene Way Sr										1:30p	
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	neral ector		5. Social Security Number 220-36-2416 Usual Residence of Decedent	X 2□ F 7. Ag	e (In yrs. last	Yrs.	Months	1 Year Days	If Under Hours	Min.	8. Date of Bin (Month, Da 3 – 20 –	1 9 4	1 MD 9. Birt	hplace (State or Fountry)
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of H			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I	Removal from State	20b. Place ceme	of Dispo	sition (Nan natory or o	ne o <u>f</u> ther b iac	c	Da	ite	20c. Lo	ocation - City or	Town, State
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this certificat	rector,	0	25. Was case referred to medical						26. Place	of Death	Check only o		1.3.103	
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within 2	сощ	Me	29b. Signature and title of certifier				29c	. License	number			29d. Dat	te signed (Monti	n, Day, Year)
1	4		30. Na and address of person who co	ampleted assess of	anah (la :		D	004.	5445			5/	21/12	
ク'	Sta	te	JAWE 4. (LICK NO 31. Date filed (Month, Day, Year) MAY 2.12	1(65 Last	brilla	D. S	rlibn	×7, A	0 2181	oy		·	··· ·	

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Amend #8 per Fh g941 7/16/13 TRT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 5:25 PM Frank Thomas Williams, Sr. may 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town or Location of Death Examiner Princess Anne Aurora Senior Living of Mandkin

Social Security Number 6. Sex 7. Age (In yrs. last birtho Somerset | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 10/12/1918 6. Sex 1 → M 2 □ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 216-12-1100 Director VA Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location items 23a or 28a-f show 10d. Inside City Limits Director 1 ☐Yes 🎾 No MD Worcester Pocomoke 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 925 Clark Avenue Funeral 21851 12. Was Decedent Ever in U.S. Armed Forces?

Y Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married ortant: If item 27 is marked other than "natural", or i injury or other traumatic event, the Medical Exami Baltimore, Maryland 21215-0036 SpecifyBlack 1 ☐ Yes 2 🕅 No If Yes, Give Army Specify 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'amy injury or other traumatic event, the Magnos. Elementary/Secondary (0-12) College (1-4or 5+) 6 Farmer Self-employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ ပ Thomas Williams Ruth Cottman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace Williams/Wife 925 Clark Avenue, Pocomoke, MD 21851 20b. Place of Disposition (Name of cemetery, crematory or other patem 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Tindley Chapel 4 ☐ Donation 5 ☐ Other (Specify) 5-17-2012 Pocomoke, MD 22. Name and Address of Facility 17 W. Isabella St. 21. Signature of Funeral Service Licenses Home Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Dement disease or condition resulting in death) 74 cars /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transi and Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy Hospital or Attending Physician; The certificate performed Division of Vital 1 □Yes 2 ☑No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manper of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number DR. USHA NATESAN 8051359 178 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1415 - S. DIVISION ST. SALISBURY, MD 21804 DR-USHA NATESAN 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State MAY 17 Registrar

DHMH 17 Rev 1/2001

William

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}2012 Elizabeth Pusey Wooten May 10, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5457 Market Street Snow Hill Worcester 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 1 □ M 2 🟋 F 73 218-34-7926 06/05/1938 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MDWorcester Snow Hill 1¶Yes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 5457 Market Street 21863 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14 Bace - American Indian 1 ∐Yes 2 ₩ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 21 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk County Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fred Pusey Cora Perdue 19a. Informant's Name/Relationship (Type. Print) Sidney R. Wooten/spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5457 Market Street, Snow Hill, MD 21863 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Spence Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 05/14/2012 Snow Hill, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home, 13 E Grove St, Delmar, DE 1994D 23a. Part 1. Enter the disease, or composhock, or beartfallure. List on the composhock of the composition of that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. Approximate Interval Between Onset and Death cation Immediate Cause IFinal Metostotic disease or condition resulting in death) months Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Jause Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) g ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

by Funeral

Completed

Be

2

r than "natural", or items 23a or 28a-f sho

hours after

within 72

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, In M.

Baltimore, Maryland 21215-0036

that the death certificate be executed burial-tra physician nding p 0 detached page 2 s director this

Box 68760.

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Examine Physician/Medical 2 Completed Be

Division of Vital Records, Physician: The law requires After Hospital or Attending death. within 24 hours after death To the Funeral Director: filled in by the completely

Certification: To 6 Could not be determined 4 - Homicide Medical 29a. Certifier (Check only 29b. Signature and title of certifier MART TIN 32. Reg State Registrar

5 | Pending

27. Manner of Death

2 Accident

3 Suicide

1 Natural

Other: 4 \sum Nursing Home 5 Residence 6 \subseteq Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Investigation 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 30690

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Grall St. 501.3600, MD 21801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May Month Mary Zois 2012 02:15Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death South River Health & Rehab. Center Edgewater Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Min Hours (Month, Day, Year) Director 089-24-9738 1 □ M 2 □XF 97 Albania 08/13/1914 should be filed within 72 hours word.
In and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f show are the standard of the Medicel Examiner must be notified at the manual of the Medicel Examiner must be notified at the manual of the Medicel Examiner must be notified at the manual of the manual of the Medicel Examiner must be notified at the manual of the 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Marvland Anne Arundel Annapolis 1 🗆 Yes 2 ី No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21401 USA 1915 Towne Centre Blvd. #1009 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black. White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Clothing Seamstress other treumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lolis Ourania Chamberis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Importent: If item 27 is eny Injury or other treu 1915 Towne Centre Blvd. #1009 Annapolis, MD 21401 Theodore Zois/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other Date 20c. Location - City or Town, State 1 🕅 Burial 🤰 🗌 Cremation 3 🗋 Removal from State National Mem'l Park 5/18/2012 Falls Church, Virginia 4 Donation 5 Other (Specify) 21. Signati 22. Name and Address of Facility George P. Kalas Funeral Home LAS 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Pan 1. Enter the disease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau'e on each line. Immediate Cause (Final Onset and Death Physician/ -DIDMY0 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed burlal-tran that initiated events resulting in death) Last Due to (or as a consequence of): physicien a Physician/Medical Box 68760 ettending property for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day Year Yes 2 No ed by the e 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signe should be 1 Yes 2 No 3 Probably 4 Honknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: ြုပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) nin 24 hours after death. The Funerel Director: After thi Objetely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2
To the I only one) 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) drive Ellicott city nd 21042 05

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Minnie Ames Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Levindale Nursing Home Baltimore If Under 1 Year If Under 24 Hrs. . Social Security Number 7. Age (In yrs. last birthday) Funeral 6 Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Min. Months 1 □ M 2 👽 F Hours Director 220-22-9235 91 റ് 10 MΠ Usual Residence of Decedent 28a-f show 10b. County aţ 10a. State 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director must be notified MD Baltimore 1X Yes 2 ☐ No NA o 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral 6927 Glenheights Road 21215 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Examiner o. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2**X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. "natural", Completed 3 😾 Widowed 4 🗆 Divorced Black Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Teachers Baltimore City Aid na other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John W. Cooper Sr. Lucinda Hinton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenheights Road, Baltimore, Md 21215 Linda Ames-Daughter 6927 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 and Department of N cemetery, crematory or other place) - 6 1 XBurial 2 Cremation 3 Removal from State Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 6/4/2012 Memorial Arbutus, Md 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
March F/H West
4300 Wabash Av Baltimore, 21215 Ave 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ach line. shock, or heart failure. List only one cause Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for es e consequence of if any leading to in medi-cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been a 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2 1 25. Was case referred to medical Be 26. Place of Death (Come only one) examiner? Certificate: To 1 Tes Other 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner Death funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? Accident 1 Yes 2 🗌 No Investigation 3 Suicide
4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) -4-201 30. Name and address of person who completed cause of death (Item 23a) (Type, 2434 West Belvedere Arome buind

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 XM 2 ☐ F Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 Pres 2 □ No 1timore Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a or Injury or other traumatic event, the Medical Examiner must be r Funeral Was Decedent Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 3 No <u>8</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) rui'sor 17. Father's Name (First, Middle, Last, Be Pages 1 and 2 should be f nent of Health and Mental I int: If item 27 is marked of 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heal 20a. Method of Disposition 1 ☐ Burial 2 KCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Sovice Licensee MO155 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dish, shock, or heart failure. List only one cause on each line. AID Immediate Cause (Final disease or condition resulting in death) hysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed signed by the attending physician and abe detached for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐Ectopic pregnancy Year Day 5 Other (specify) ☐Yes 2☐No 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed page 2 should this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number D0069314 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) from 8813 Woltham 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- For State of Maryland / Dep	partment of Health and Nertificate of Death	Mental Hygiene	990			
æ	Physici /Medic		1. Decedent's Name (First, Middle, Last) Anne Boschini		Month Day Year	of Death			
	Examin		4a. Facility Name (If not institution, give street and number) Transitions Healthcare	4b. City, Town, or Location of Death Sykesville	4c. County of Death Carrol1				
	Funeral Director		5. Social Security Number $6. \text{ Sex}$ $1 \square \text{ M} 2 \cancel{X} \text{F}$ 69 Yrs.	May 22, 1943 West Virg	e or Foreign inia				
at yielild AIA 13-0030 should be filed within 72 hours after death with the Maryland nd Mental Hyglene. In arked other then "neturel", or Items 23a or 28a-f show umatic event, the Modfal Exc. iller frant be notified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Carroll Sykesvil 10c. City, Town or I Sykesvil	1e	1 ☐ Y	es 2 No				
020	urs after death v el', or Items 238	by Funeral Director	13. Marital Status 1. Married Status 1. Never Married 2. Married 3. Widowed 4. Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1. Yes 2. No If Yes, Give Year or Dates:	21784 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes XN No Specify: Specify: White					
0-C1717 n	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel," or ftems 23a or 28a-f show any injury or other traumatic event, the Marical Ex., there is an the nutilised at once.	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) e Maker 18. Mother's Nam	Own Home (First, Middle, Maiden Sumame)				
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Daltilliore	Pages 1 nent of He ent: If iten ury or oth		'4 □Donation 5 □Other (Specify) Metro Cr	ematory or other place)	Date 20c. Location - City or Town, State 7/2012 Baltimore, Maryla	ınd			
Dall	permit. Departi Importi any inj		21. Signature of Fune al Service Licensee Stephanie Custer		mation Society of Maryla Baltimore,Maryland 21228				
,00,00	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and proposed proposed in part of the funeral director, page 2 should be detached for use as the burial-transit at the proposed p	dical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	an ferry dio	Interval E Onset ar	id Death			
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	Le V		30. Name and address of person who completed cause of death (Item 23a) (Type Washington (Item)	Deckment	me				
	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 7 2012 June 32. Registrar's genature	· · · · · · · · · · · · · · · · · · ·					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 30 per dvr 9928 6-7-12 yt. State of Maryland Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2012 June Anna Marie Benny Medical 9:35A **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 412 Malcolm Drive, Suite 310 Westminster Carroll Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 212-28-0174 **Director** 83 1 □ M 2 🗓 F April 6, 1929 MD Yrs Usual Residence of Decedent 28a-f show 10a. State at 10c. City, Town or Location 10d. Inside City Limits Director notified MD Carrol1 1 ☐ Yes 2X No Sykesville 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? be Funeral 23aitems 23 ner must 135 Dixon Lane 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: 3 X Widowed 4 □ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene Important: If item 27 is marked other tha any injury or other traumatic event, the Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Busick Charlotte Josephine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Joann Campion (Daughter) 135 Dixon Lane Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Page 1 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest Vet. 6/13/2012 Owings Mills, MD 21. Signatura of Funeral Service License 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, P.A. MOCTEY PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ liver ireacc with encupalogothy Medical Due to (or as a consequence of): **Examiner** tago dicait End 2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine for use as the burial-trans Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the all 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Dr. 's office funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Murse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 1002002 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ana I. Sarante 1645 Liberty Rd. Suite 204 Sykesville, Md. JUN 0 7 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Georgina Bucci 230 UNE 2012 /Medical 4a. Facility Name (If not institution, give_street and number) 4b. City, Town? or Location of Death 4c. County of Death **Examiner** HARFO ELCA KIVERSIDE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2√2 F Months Hours 217-58-9690 60 **Director** 25, Aug. 1951 Maryland Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination must be maithed at Director Maryland 1 ☐ Yes 2000 No Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17 Rader Court 21234 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11 Marital Status 1 ☐Yes 20 If Yes, Give Year or Dates: 1 Never Married 2 Married **₹**CKNo 1 □Yes XXNo Specify. þ Specify: White 3 Widowed XX Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 72 Elementary/Secondary (0-12) College (1-4or 5+) Cashier Grocery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be William Krajci Charlotte Spangler ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Truckenmiller / Sister 637 N. Branch Court Abingdon, Maryland 21009 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 5 Pages 1 Evans Funeral of Chapel 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐Other (Specify) 2012 Forest Hill, Maryland 4 □ Donation Bel Air Evans Funeral Chapel & Cremation Service-BelAir 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximal shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 2 Pimers disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Eiter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 □Yes 2 No 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 2 Accident 1 ☐ Yes 2 No filled in by the within 24 hours after deatl To the Funeral Director; 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

DHMH 17 Rev 1/2001

29b. Signature and title of certifie

30. Nam, and address of person

32. Registrar's Signature 31. Date filed (Month, Date

who completed cause of death (Item 23a) (Type, Print)

MM

29c. License number

29d. Date signed (Month, Day, Year)

Huspital or Attending Physician: filled in by 24 hours a within 2

> Melissa Brassell, MD Assistant Medical Examiner

> > OCME

29b. Signature and title of certifier

32. Registr 's Sign ture

and manner stated

assel

30 Name and address of person who completed cause of death (Item 23a)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

OCME

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

June 2, 2012

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State Registra

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	Funeral Director		5. Social Security Number 6.		rs. last birthda	Months	er 1 Year	If Under 24 H Hours Mi		Birth Day, Year)	9.	Birthplace (State or Foreign Country)
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Baltimore, Maryland	permit. Page 1 and 3 Department of Healt Important: If Item 2 any Injury or other <u>9009.</u>		20a. Method of Disposition 1 Rurial 2 Cremation 3	Removal from State		crematory or	other place	xe)	Pate	20c.		y or Town, State
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9	Medical Examiner		resulting in death)	Due to (or as a cons		CTIC	147					
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130	Attending Physician: The law requires that the death certificate be executed refeath. stor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transi	Certificate:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident □ Investigat		28b. Time injur		28c. Injur worl 1 🗆	yat <br !Yes 2.∐No	28d. Descr	ibe how inj	ury occurred	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G928 6/21/2012 JH
State of Maryland / Department of Health and Mental Hygiene For State Registrar 7995 Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2012 A. BOLDEN 4: 54AM IMBERI June 02 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death HARBOR HOSPITAL BALTEMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours **Director** 1 🗆 M 2 💢 F arylana or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. aţ 10a. State 10b. County 10c. City, Town or Location Director Examiner must be notified Himore 1 XYes 2 ☐ No 10g. Citizen of What Country? items 23a Funeral USA 12 Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married ō Completed by 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Black "natural" 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natur
ampiniury or other traumatic event, the Medical I
once. 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bou ihor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura Route Number, City or Town, State, Zip Code) Baltimore, MD 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of Milme Garmetery 06/18/2012 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signal e of Funeral Service License 21202 101 orth 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner NEUMONTA unknown Secusitially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last Neutropenia unknown attending physician and Due to (or as a consequence of) Physician/Medical HI. Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death
Unknown Day Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco ase contribute to the cause of death? Completed by ASTHMA the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown DIABETES MEILETUS IL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 2 No 2 No __ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dinpatient 2 ER/Outpatient 3 DOA funeral 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Vatural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation filled in by the Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-001 JUNE 02 ndhu ka 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Indhira 3001 S. HANOVER STREET BALTIMORE MIN 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Angela Corde Physician/ Gonzalez Cardenas AKA Month Year 9:20 PM 2012 Marie Gonzalez Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Battimore Koad Baltimore 6un Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 □ M 2 🕅 F Days (Month, Day, Months Hours Min **Director** 15-76-8885 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 21227 U.S.A. 701 Gun Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Deceue... Armed Forces? Yes 2 No 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, 1

Never Married 2 ☐ Married Black, White, etc. þ 21215-0036 1 XYes 2 No Specify: Cuban If Yes, Give Year or Dates Specify: Hispanic 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2th Teacher School grade Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ <u>Leoncio Gonzales Rodriquez</u> <u>Carmen Cardenas Santa Maria</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister Clarice Proctor, OSP 701 Gun Road, Baltimore, Md 21227 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place 6/8/2012 Loudon Park Baltimore, 22. Name and Address of Facility
March F/H West
4300 Wabash Av Signature of Funeral Service License Ave, <u>Baltimore.</u> 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ advanced 'ears Medical Due to (or as a consequence of) Examiner Parkinsons 1 Cars Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by osteoporus,3 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) \(\text{Convex} \) 2 No Hospital: 1 🗌 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🛄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated The certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) R16229 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Holden Ralfinure 31. Date filed (Month, Day Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9966 16:40 pm SUNCE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore n/a Hospita If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 64 214-50-9828 Director 1 □ M 2 🗓 F March 1,1948 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth end Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Eventral mat be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21061 821 Bentwillow Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) General Offices Office Employee 12 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ethel Barnett Richard Woolridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert J. Crigger/husband Bentwillow Drive Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, Inc. 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/05/2012 Baltimore, Maryland 21. Signature of Funeral Service Licensee Stephanie Custer 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 5ep\$\(\frac{1}{2}\)5 Due to (or a a consequence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death 9 Unknown 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) 8 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certificate: To 1 Npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature of death (Item 23a) (Type, Print) 1800 Orleans Street Baltimor, Hd 21287 led (Month, Day, State JUN 0 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joseph William Collins June 4, 7:40 a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Kline Hospice House Mount Airy Frederick . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours 174 -36-7580 Director 66 Yrs. 1 X M 2 □ F April 3,1946 Pennsylvania Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Maryland Frederick Frederick 1 Yes 2 No 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? Funeral 6348 Claridge Drive North 21701 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. by 1 Never Married 2 Married "natural", or 1 Tes 2 X No Specify Specify: White Completed 3 Widowed 4 Divorced and Mental Hygiene.

is marked other than "natural aumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Laboratory Technician SAIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) |William Joseph Collins Catherine Donohue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tracence. Barbara H. Collins / wife 6348 Claridge Drive North Frederick, MD. 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 06/06/2012 | Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland Inc we of Funeral Service Licensee Stephanie Custer 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Weeks 0 Immediate Cause (Final Physician/ Hemorrhageic Stroke disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Medulloblastoma of the brain Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury Coronary Artery Disease burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicis Diabetes as the b use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery for 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day 1 Yes 2 9 Unknown detached signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by History of multiple traniet ischemic attacks page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy pertorm death? 1 ☐ Yes 2 👿 No 1 ☐ Yes 2 😿 No To the Hospital or Attending Physician:] within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) hospice 1 Yes 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending

Division of Vital Records, P.O. Box 68760

Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D50600

1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Silvia Shih, MD. 1433 Porter Street Fort Detrick, Maryland 21702

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Investigation

determined

6 Could not be

Accident Suicide

4 Homicide

29a. Certifier

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) Physician/ Medical 4a. Facility Name (if not institution, give street and number, City, Town, or Location of Death **Examiner** Baltimore Co. Windsor Mill 3103 Northmont Rd 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Nursbort 4 **Funeral** Months Hours 1 □ M 2**X** F 10/13/1931 Director Yrs 80 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shorexaminer must be notified at with the Maryland Director Baltimore Co. Windsor Mill 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? U.S.A 21244 Funeral 3103 Northmont Rd. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 K No Specify If Yes Give Black "natural", 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Springfield State Il Hygiene. 12th Grade College (1-4 or 5+) Hospital the Nurse nt of Health and Mental Hygi If item 27 is marked other or other traumatic event, I Be 18. Mother's Name (First, Middle, Maiden Sumame)
Helen Rosie Green 17. Father's Name (First, Middle, Last) Samuel Carson Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3309 Turgot Ln., Windsor Mill, MD 21244 Jay Patterson (son) 20a, Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State pern it. Page Department of Important: If any injury or Resthaven Mem. 06/07/12 Frederick, MD 4 Donation 5 Other (Specify) Fareral Service Licen 2705ephdrn of Brown Jr. Funeral Home PA Signature 142140 N. Fulton Ave., Baltimore, MD21217 23a/Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each list. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami use as the burial-trar and that initiated events Due to (or as a consequence of) resulting in death) Last attending physiciar Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Year Day 5 Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 Yes 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? ပ 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manne Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) iniury Matural 5 Pending s after death. Accident Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. n's Name (First, Middle Aast) 2. Date of Death 3. Time of Death Physician/ Month 3:44 AM 2017 Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** altimore Mospita If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month. Director M 2 DE -1931 shana permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If firem 27 is marked other than "natural", or itematically or other trainments. 10a. State City, Town or Location 10d. Inside City Limits **Funeral Director** onsville 1 Yes 2 No timore 10g. Citizen of What Country? 21228 Ghana Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Black, White, etc. 2 No Completed by 1 Never Married 2 Married 1 Yes 1 Yes 2 No Specify. 3 - Widowed 4 Divorced thrican Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Giro kind of Pork done during most of working liff. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) 01 Be မ nship (Type, (ii)) Cuighter 20a. Methodrof Disposition 20b Place of Disposition (A cemetery, crematory ■Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death PSIS Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Cancerwith metastases ostate 2201 Sequentially list conditions, it is a cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No for Pregnant at time of death Month Dav Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Yes 2 funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🗆 Yes 2 🗆 No 5 Pending Natural injury Accident Investigation within 24 hours after deatl

To the Funeral Director;
completely filled in by the Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) To the 29b. Signature and title of certific 29c. License number 29d. Date signed (Month. Dav. Year) 02,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 S. CATON AVENUE BALTIMORE 31. Date filed (Month, Day, Year) State 2012 JUN 0 7 Registrar